

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMEDNDE ITEM #23a PER MD G774 8/25/99 AH

26501

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Kodumthara Luke Thomas

2. Date of Death

August 9, 1999

3. Time of Death

11:15pm

4a. Facility Name (If not institution, give street and number)

7908 Kara Court

4b. City, Town, or Location of Death

Greenbelt

4c. County of Death

Prince George

5. Social Security Number

379-64-9858

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

4/17/45

9. Birthplace (State or Foreign Country)

Kerala

Usual Residence of Decedent

10a. State

Md

10b. County

P.G.

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7908 Kara Court

10f. Zip Code

20770

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asisan Indian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Kodumthara Mathew Lukose

18. Mother's Name (First, Middle, Maiden Surname)

Thankamma Thomas

19a. Informant's Name/Relationship (Type, Print)

Pennamma Thomas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7908 Kara Court Greenbelt Md 20770

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate Of Heaven

Date

8/14/99

20c. Location - City or Town, State

Silver Spring, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Snead Mortuary Service
P.O. Box 5804 Capitol Heights, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC HEPATOBIILIARY CARCINOMA

*8months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 33224

29d. Date signed (Month, Day, Year)

August 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ram Trehan, M.D. 50 West Edmonston Drive Rockville, MD 20852

State
Registrar

31. Date filed (Month, Day, Year)

AUG 12 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

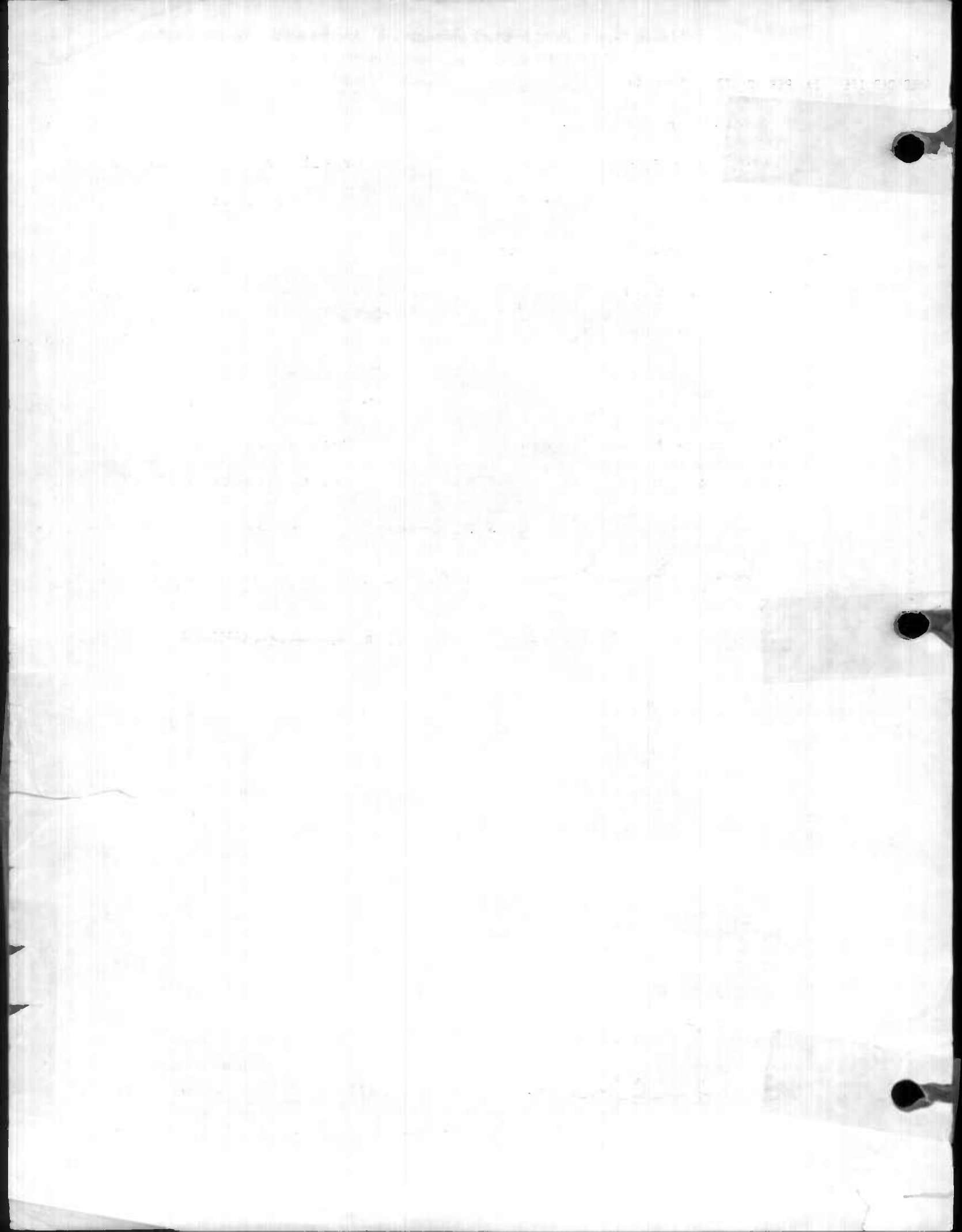
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26502

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Liddie Alberta Taylor | | | | 2. Date of Death Month Day Year August 5 1999 | | 3. Time of Death 11:55 PM | |
| | 4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital | | | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick | |
| Funeral Director | 5. Social Security Number 218-30-9086 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec 3, 1906 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Frederick | | 10c. City, Town or Location Frederick | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 750 Carroll Parkway | | | | 10f. Zip Code 21701 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nursing Assistant | | | 16b. Kind of Business/Industry Health Care | |
| 17. Father's Name (First, Middle, Last) James William HOAR | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gertie Manzella MERRYMAN | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Harold D. Taylor/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 513 Elm Street, Frederick, Maryland 21701 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery | | | Date Aug 9, 1999 | | 20c. Location - City or Town, State Frederick, Maryland | |
| 21. Signature of Funeral Service Licensee <i>Kathleen Roberson</i> M00706 | | | | 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic Heart Disease | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Casper E. Cline, III</i> | | | | 29c. License number D16428 | | 29d. Date signed (Month, Day, Year) 8/6/99 | | |
| 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) Casper E. Cline, III, M.D., 300 West Ninth Street, Frederick, Maryland 21701 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 09 1999 | | 32. Registrar Signature <i>B. Spate</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26503

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harvey Phillip Tobery

2. Date of Death

August 7, 1999 7:20AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Frederick Health Care Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

214-10-3049

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 16, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Middletown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

18 Linden Blvd.

10f. Zip Code

21769

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

owner/operator

16b. Kind of Business/Industry

meat market

17. Father's Name (First, Middle, Last)

Charles Tobery

18. Mother's Name (First, Middle, Maiden Surname)

Annie Tobery

19a. Informant's Name/Relationship (Type, Print)

Kathleen Tobery, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18 Linden Blvd., Middletown, MD 21769

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Frederick Mem. Park at 8/10/99 Frederick, Maryland
Linden Hills

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ryan M. Berger

MO0999

22. Name and Address of Facility Keeney and Basford Funeral Home
106 East Church Street, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Severe C.O.P.D

Approximate Interval Between Onset and Death

10 years

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Dementia - alzheimers

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jon S. Griston MD

29c. License number

021944

29d. Date signed (Month, Day, Year)

8/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jon S. Griston MD 300 W 9th St. Frederick, MD 21701

31. Date filed (Month, Day, Year)

AUG 10 1999

32. Registrar's Signature

A. Sparto

State
Registrar

Baltimore, Maryland 21215-0020

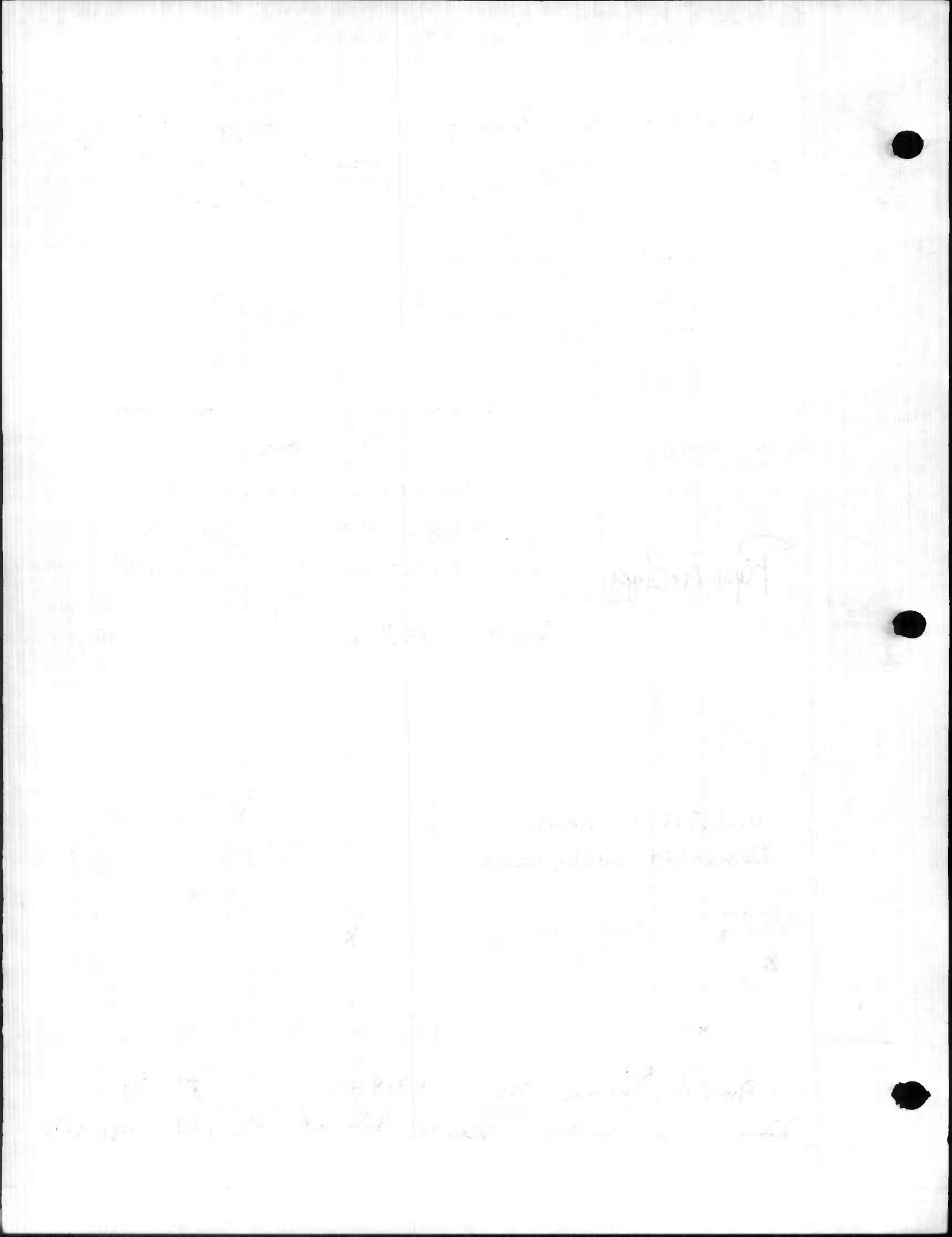
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.




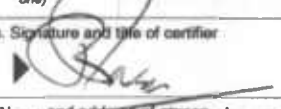
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-26504

| | | | | | | | |
|--|---|---|---|--|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) AGIS D. VALAKOS | | | | 2. Date of Death Month Day Year Aug 9 1999 | | 3. Time of Death 1445 |
| | 4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL | | | | 4b. City, Town, or Location of Death SILVER SPRING | | 4c. County of Death MONTGOMERY |
| Funeral Director | 5. Social Security Number 119-14-3187 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 72 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) MARCH 29, 1927 | 9. Birthplace (State or Foreign Country) NEW YORK |
| | Usual Residence of Decedent | | | | | | |
| 10a. State MD. | | 10b. County MONTGOMERY | | 10c. City, Town or Location KENSINGTON | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 3333 UNIVERSITY BLVD. W. | | | | 10f. Zip Code 20895 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ENGINEER | | 16b. Kind of Business/Industry ENGINEERING | |
| 17. Father's Name (First, Middle, Last) DEMETRIUS E. VALAKOS | | | | 18. Mother's Name (First, Middle, Maiden Surname) IRENE GENNAROS | | | |
| 19a. Informant's Name/Relationship (Type, Print) BARBARA K. VALAKOS/WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6417 HOLLINS DR., BETHESDA, MD. 20817 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY | | Date 8/11/99 | | 20c. Location - City or Town, State RIVERDALE, MD. | |
| 21. Signature of Funeral Service Licensee  MO0091 | | | | 22. Name and Address of Facility CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20906 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death 1 month |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE CLOSTRIDIUM DIFFICILE COLITIS SEIZURES | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D 28656 | | 29d. Date signed (Month, Day, Year) AUGUST, 9, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAVI VASSI, MD 8609 SECOND AVE, #404 B SILVER SPRING, MD 20910 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | 32. Registrar's Signature  | | | | | |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) RAY EDGAR VALENTINE | | | | 2. Date of Death Month Day Year AUG. 8, 1999 | | 3. Time of Death 9:10pm | |
| 4a. Facility Name (If not institution, give street and number) FREDERICK HEALTH CARE CENTER | | | | 4b. City, Town, or Location of Death FREDERICK | | 4c. County of Death FREDERICK | |
| 5. Social Security Number 213-18-9027 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) APRIL 11, 1920 | |
| 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MARYLAND | | 10b. County FREDERICK | | 10c. City, Town or Location FREDERICK | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 6889 Crabapple Ct. | | 10f. Zip Code 21703 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CONSTRUCTION | | 16b. Kind of Business/Industry INSPECTOR | | | |
| 17. Father's Name (First, Middle, Last) HARRY VALENTINE | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARIE FITZ | | | |
| 19a. Informant's Name/Relationship (Type, Print) RANDOLPH VALENTINE (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 DOGWOOD AVE., THURMONT, MD 21788 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. TABOR CEMETERY | | Date 8/11/99 | | 20c. Location - City or Town, State ROCKY RIDGE, MD | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN ST., THURMONT, MD 21788 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>a. Pneumonia Due to (or as a consequence of):</p> <p>b. Cerebrovascular Accident Due to (or as a consequence of):</p> <p>c. Ischemic Heart Disease Due to (or as a consequence of):</p> <p>d.</p> </div> </div> | | | | | | Approximate Interval Between Onset and Death 2 Days 3 Weeks | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number D0031058 | | 29d. Date signed (Month, Day, Year) AUGUST 11, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GENE F. ASHE, M.D. WOODSBORO MEDICAL CENTER, WOODSBORO, MD 21798 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1999 | | 32. Registrar's Signature  | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #19 PER F.H. G775 9-18-99 WR.

Certificate of Death

Reg. No.

99 26506

| | | | | | | | | |
|--|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Margaret Flora Cuthbert Wittich | | | | 2. Date of Death Month Day Year August 6, 1999 | | 3. Time of Death 6:40 PM | |
| | 4a. Facility Name (If not institution, give street and number) Bedford Court Nursing Center | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery County | |
| Funeral Director | 5. Social Security Number 108-30-1954 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) March 31, 1915 | |
| | 9. Birthplace (State or Foreign Country) New York | | 10. Usual Residence of Decedent | | 10a. State MD | | 10b. County Montgomery | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Derwood | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 18012 Mill Creek Drive | | 10f. Zip Code 20855 | |
| | 10g. Citizen of What Country? U.S.A. | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| To Be Completed by Physician/Medical Examiner | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed | | 16b. Kind of Business/Industry Boating Business | |
| | 17. Father's Name (First, Middle, Last) Alexander Biggar Cuthbert | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Schopp | | 19a. Informant's Name/Relationship (Type, Print) JUDITH MCLEOD - Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18012 Mill Creek Drive Derwood, MD 20855 | |
| Physician /Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ocean View Cemetery | | 20c. Date 8/11/99 | | 20d. Location - City or Town, State Staten Island, NY | |
| | 21. Signature of Funeral Service Licensee <i>James W. Love</i> | | 22. Name and Address of Facility Capitol Funeral Service, Inc. 7211 Lee Hwy Falls Church, VA 22046 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Broncho Pneumonia</i> Due to (or as a consequence of): | | Approximate Interval Between Onset and Death days | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Brain Tumor</i> <i>Cerebrovascular Accident</i> | | 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| State Registrar | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| | 29b. Signature and title of certifier <i>Lee Jonathan Musher MD</i> | | 29c. License number D33357 | | 29d. Date signed (Month, Day, Year) 8/7/99 | | 30. Name and address of person who completed cause of death (item 23e) (Type, Print) <i>Lee Jonathan Musher MD 5530 Wisconsin Ave Chevy Chase MD</i> | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | 32. Registrar's Signature <i>Benita G. Sparks</i> | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26507

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LYOIA M. WHARTON

2. Date of Death

Month
AugustDay
6Year
1999

3. Time of Death

0520

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

216-46-2932

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
February 22, 1901

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11005 Rosemont Drive

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Koller

18. Mother's Name (First, Middle, Maiden Surname)

Cecelia Jacques

19a. Informant's Name/Relationship (Type, Print)

Joseph F. Ferraro/Nephew In Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1127 Bluebird Drive Munster, Indiana 46321

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

August 9, 1999

Parklawn Memorial Park

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

M00335

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/

Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

AUGUST 6, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL I. MARGOLIS, MD 11404 Old Georgetown Road Rockville, Maryland 20852

State Registrar

31. Date filed (Month, Day, Year)

AUG 10 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-26508

| | | | | | | | | |
|---|---|---|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CHESTER JAMES WATSON | | | | 2. Date of Death Month Day Year July 22, 1999 | | 3. Time of Death 10:07 PM | |
| | 4a. Facility Name (If not institution, give street and number) Meredian-Corsica Hills Nursing Center | | | | 4b. City, Town, or Location of Death Centreville | | 4c. County of Death Queen Anne's | |
| Funeral Director | 5. Social Security Number 214-32-0330 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 20, 1916 | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State Md. | | 10b. County Queen Anne's | | 10c. City, Town or Location Centreville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 3014 Church Hill Road | | 10f. Zip Code 21617 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction/Labor | | 16b. Kind of Business/Industry Cutalone Constr. Company | | | |
| | 17. Father's Name (First, Middle, Last) James Fitzgerald Watson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Betty Anne Fitzgerald | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Betty A. Romanowski-Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5758 Rodman St., Phil, Pa. 19143 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesterfield Cemetery | | 20c. Location - City or Town, State Centreville, Md. | | 20d. Date July 27, 1999 | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 408 S. Liberty St., Centreville, Md. | | | |
| | 23a. Part I. Enter the disease, or combination of diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrovascular disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Approximate Interval Between Onset and Death 1M | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D32036 | | 29d. Date signed (Month, Day, Year) 7/23/99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Geor J Sprane 2108 W. Park Drive Chester, MD 21619 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 26 1999 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

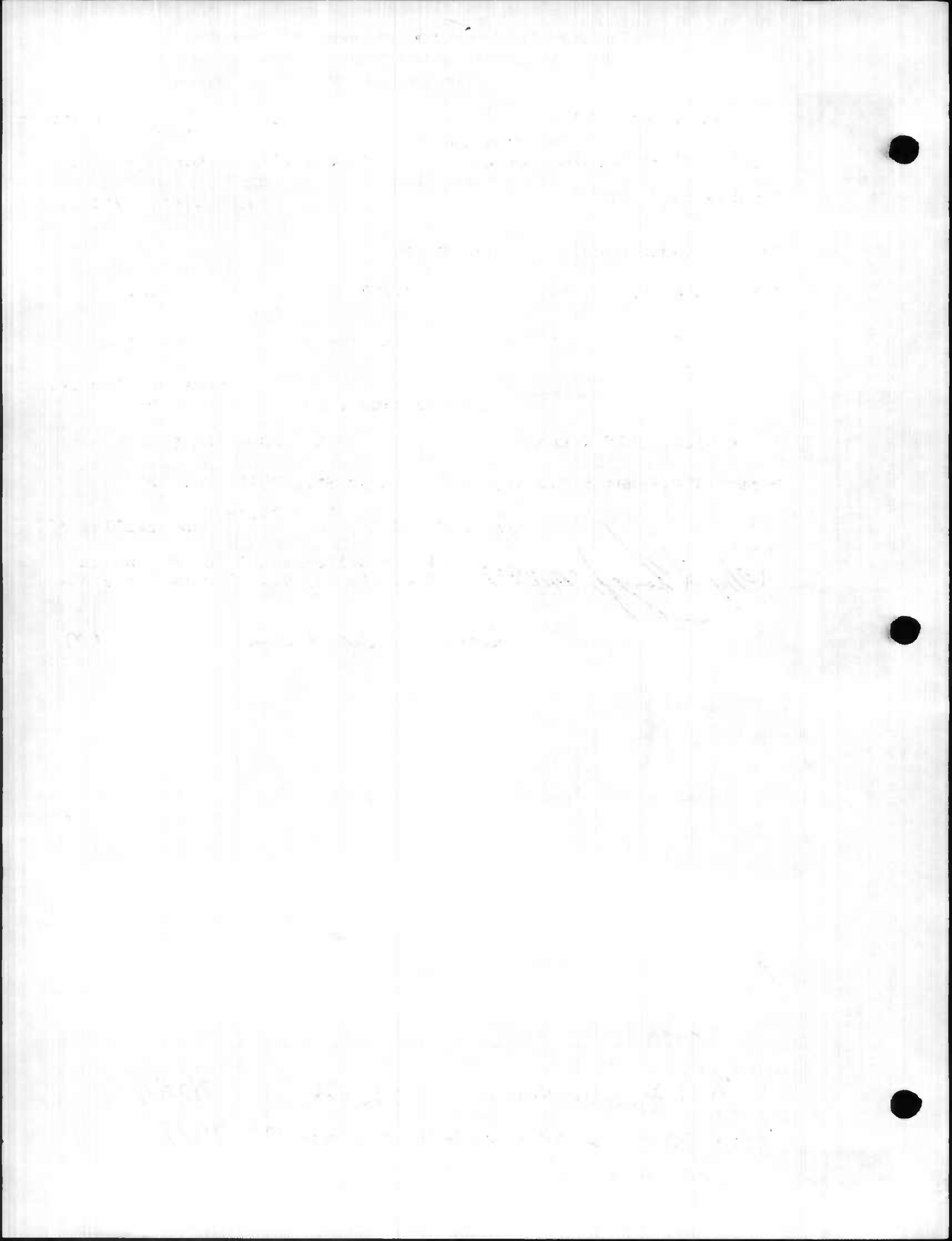
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26509

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CREETY IRENE WOLFE

2. Date of Death
Month Day Year
August 1, 19993. Time of Death
0823

4a. Facility Name (If not institution, give street and number)

Easton Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

430-44-4594

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 28, 1926

9. Birthplace (State or Foreign Country)

Arkansas

Usual Residence of Decedent

10a. State

MD

10b. County

Queen Anne's

10c. City, Town or Location

Stevensville

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

304 Chenowith Drive

10f. Zip Code

21666

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Practical Nurse

16b. Kind of Business/Industry

Nursing

17. Father's Name (First, Middle, Last)

John Julian Holt

18. Mother's Name (First, Middle, Maiden Surname)

Buena Robinson

19a. Informant's Name/Relationship (Type, Print)

Evelyn B. Strawser - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

304 Chenowith Drive, Stevensville, MD 21666

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oakland Cemetery

Date

Aug. 7, 1999

20c. Location - City or Town, State

Oakland, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.
106 Shamrock Road, Chester, MD 2161923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

CHOLANGIOCARCINOMA

Approximate
Interval Between
Onset and Death

2 YRS.

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

UPPER GASTROINTESTINAL HEMORRHAGE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DL3862

29d. Date signed (Month, Day, Year)

08.01.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott D. Friedman, MD, 403 Marvel Court, Easton, MD 21601

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

B. Sparks

State
RegistrarCreety Wolfe
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
2025To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Amended

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

line 20C./SC

State of Maryland / Department of Health and Mental Hygiene

7-23-99

WCHD & Line 26. 8/16/99 Certificate of Death

Reg. No.

99 26510

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Laurie Ann Wheeler

2. Date of Death

Month

Day

Year

07

21

99

3. Time of Death

12:30PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

101 Roosevelt Drive

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

5. Social Security Number

227-02-1217

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

28

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

March 11, 1971

9. Birthplace (State or Foreign Country)

Mass.

Usual Residence of Decedent

10a. State

Colorado

10b. County

Larimer

10c. City, Town or Location

Loveland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1802 Chama Avenue

10f. Zip Code

80538

10g. Citizen of What Country?

USA

11. Marital Status

XX Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Recreation Co-Ordinatory Municipal

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Raymond Wheeler RAYMOND WHEELER

18. Mother's Name (First, Middle, Maiden Surname)

Marie Daniels

19a. Informant's Name/Relationship (Type, Print)

Jimmie Bostic (Fiance)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1802 Chama Avenue, Loveland, Co. 80538

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery 7/24/99 Marlborough, Mass.

Date

20c. Location - City or Town, State

Marlborough, Mass.

21. Signature of Funeral Service Licensee

M-00849

Paul T. Lodestamp

22. Name and Address of Facility

Inman Nationwide Shipping

1605 Merwin Avenue, Cleveland, Oh. 44113

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Oligoastrocytoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

11 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

Parent's residence

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul T. Lodestamp

29c. License number

H46326 (Md)

29d. Date signed (Month, Day, Year)

7/21/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Randi Broman, PO 6190 Georgetown Blvd, Eldersburg, Md 21784

31. Date filed (Month, Day, Year)

AUG 16 1999

32. Registrar's Signature

G. Spatz

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26511

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES ELWOOD WILLIAMS, SR.

2. Date of Death

Month Day Year
AUGUST 4, 1999

3. Time of Death

1:15 p.m.

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

224-52-5081

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Apr. 17, 1933

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

650-F Heather Ridge Dr.

10f. Zip Code

21702

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1953-60

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

typesetter

16b. Kind of Business/Industry

newspaper

17. Father's Name (First, Middle, Last)

Walter Moore Williams, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Florence Robinson

19a. Informant's Name/Relationship (Type, Print)

Betty Hann-sister-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

810 East Patrick Street, Frederick, MD 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

8/7/99

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Ryan M. Berger

MO0999

22. Name and Address of Facility

Keeney and Basford Funeral Home

106 East Church Street, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line.

Immediate Cause (Final disease or condition resulting in death)

a. EMPHYSEMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

12 yrs

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Neil Waravdekar

29c. License number

D47611

29d. Date signed (Month, Day, Year)

August 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEIL WARAVDEKAR, MD 1475 TANEY AVE #204 FREDERICK, MD 21702

31. Date filed (Month, Day, Year)

AUG 09 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26512

| | | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MACK WINKLER | | | | 2. Date of Death Month Day Year AUGUST 8, 1999 | | 3. Time of Death 10:50 AM | | | |
| | 4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital | | | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick | | | |
| Funeral Director | 5. Social Security Number 498-28-0875-A | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept. 8, 1922 | | 9. Birthplace (State or Foreign Country) Tennessee | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Frederick | 10c. City, Town or Location Mt. Airy | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number 13896 Foggy Bottom Court | | | 10f. Zip Code 21771 | | 10g. Citizen of What Country? United States | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Equipment operator | | | 16b. Kind of Business/Industry Construction | | | | |
| | 17. Father's Name (First, Middle, Last) Landon H. Winkler | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Stanifer | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Mae Dean Moles Winkler, wife | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13896 Foggy Bottom Court Mt. Airy, Maryland 21771 | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Pine Grove Cemetery | | Date 8-12-99 | | 20c. Location - City or Town, State Mt. Airy, Maryland | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. VENTRICULAR FIBRILLATION Due to (or as a consequence of): b. ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | Approximate Interval Between Onset and Death | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>George I. Smith, Jr.</i> V.P.H.A. M.D. | | | 29c. License number D10587 | | | 29d. Date signed (Month, Day, Year) 8/10/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE I. SMITH, JR., M.D. VICE-PRES MED. AFFAIRS FREDERICK MEMORIAL HOSPITAL FREDERICK, MD, 21701 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26513

| | | | | | | | | | | | | |
|---|--|--|---|--|---|--|--|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Frances Elaine WORTHINGTON | | | | | 2. Date of Death Month Day Year August 10, 1999 | | 3. Time of Death 10:45 AM | | | | |
| | 4a. Facility Name (If not institution, give street and number) Northampton Manor Nursing Home | | | | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick | | | | |
| Funeral Director | 5. Social Security Number 214-10-4921 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 89 Yrs. | | 8. Date of Birth (Month, Day, Year) March 29, 1910 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| | Usual Residence of Decedent | | | | | 10a. State Maryland | | 10b. County Frederick | | 10c. City, Town or Location Frederick | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | 10e. Street and Number 527 Wilson Place | | 10f. Zip Code 21702 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Clerk | | 16b. Kind of Business/Industry Department Store | | | | |
| | 17. Father's Name (First, Middle, Last) Samuel Walter WORTHINGTON | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Hornora COOPER | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Mr. Lilburn S. Waters, nephew | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8421 Walter Martz Rd., Frederick, Maryland 21702 | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery, August 12, 1999 | | Date August 12, 1999 | | 20c. Location - City or Town, State Frederick, Maryland | | | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Richard E. Gray M00255 | | | | | 22. Name and Address of Facility Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death 24 hrs. | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Collagen Vascular Disease | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | 29b. Signature and title of certifier Austin Pearre Jr. | | 29c. License number 009689 | | 29d. Date signed (Month, Day, Year) August 10, 1999 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Austin Pearre, Jr., 300 West Ninth Street, Frederick, Maryland 21701 | | | | | 31. Date filed (Month, Day, Year) AUG 11 1999 | | 32. Registrar's Signature B. Sparks | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lawrence Bruce White

2. Date of Death

Month Day Year
August 10 1999

3. Time of Death

3:00 a.m.

4a. Facility Name (If not institution, give street and number)

109 4th Avenue

4b. City, Town, or Location of Death

Brunswick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

186-38-7535

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 2 1950

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Brunswick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

109 4th Avenue

10f. Zip Code

21716

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4or 5+)
216a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Electronic Technician

16b. Kind of Business/Industry

Secur-data, Frederick

17. Father's Name (First, Middle, Last)

Ozelle S. White

18. Mother's Name (First, Middle, Maiden Sumame)

Nancy Frank

19a. Informant's Name/Relationship (Type, Print)

Shirley S. White, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

109 4th Avenue, Brunswick, MD 21716

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hagerstown Crematory

Date

8/13

20c. Location - City or Town, State

Hagerstown, MD

21. Signature of Funeral Service Licensee

Barbara A. Williams, Owner

22. Name and Address of Facility

John T. Williams Funeral Home
100 Petersville Road, Brunswick, MD 2171623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. SQUAMOUS CELL CARCINOMA OF LUNG

Approximate
Interval Between
Onset and Death

3 mos.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 8 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wayne Allgaier MD

29c. License number

D16675

29d. Date signed (Month, Day, Year)

8/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wayne Allgaier, MD, Brunswick, MD 21716

31. Date filed (Month, Day, Year)

AUG 12 1999

32. Registrar's Signature

B. Sparks

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26515

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ollie Martha Wilt

2. Date of Death

Month Day Year
JULY 17, 1999

3. Time of Death

0840

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

218-64-8689

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar. 6, 1908

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

Allegany

10c. City, Town or Location

Westernport

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Rt. 1 Kolberg Hill

10f. Zip Code

21562

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Unknown

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Frank Somerville

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Ines

19a. Informant's Name/Relationship (Type, Print)

Pauline Russell/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15015 Paradise St. Midland, MD 21542

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Philos Cemetery

Date

7/20/99

20c. Location - City or Town, State

Westernport, MD 21562

21. Signature of Funeral Service Licensee

F. Wayne Boal

22. Name and Address of Facility

111 Church St.
Boal Funeral Home Westernport, MD 21562Physician
/Medical
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Pneumonia
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

1 day

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

A. Smith

29c. License number

D52056

29d. Date signed (Month, Day, Year)

JULY 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Albert Cruz Villanosa 925 Bishop West Road Cumberland MD 21502

State
Registrar

31. Date filed (Month, Day, Year)

JUL 21 1999

32. Registrar's Signature

B. Smith

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

1932 12 11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26516

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Rene D. Zambrana | | | | 2. Date of Death Month Day Year August 4, 1999 | | 3. Time of Death 5:30 AM | |
| 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital | | | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | |
| 5. Social Security Number 262-58-6365 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) September 9, 1927 | |
| 9. Birthplace (State or Foreign Country) Bolivia | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Darnestown | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 14900 Plainfield Lane | | | | 10f. Zip Code 20874 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: South American | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aircraft Broker & Pilot | | 16b. Kind of Business/Industry Self Employed | |
| 17. Father's Name (First, Middle, Last) Luis Zambrana | | | | 18. Mother's Name (First, Middle, Maiden Surname) Maria Luisa Delgado | | | |
| 19a. Informant's Name/Relationship (Type, Print) Elsa B. Zambrana/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14900 Plainfield Lane, Darnestown, Maryland 20874 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | Date August 6, 1999 | | 20c. Location - City or Town, State Silver Spring, Maryland | |
| 21. Signature of Funeral Service Licensee Michael E. Higgins M00846 | | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | |
| a. Pneumonia | | | | | | | |
| Due to (or as a consequence of): | | | | | | | |
| b. Hypoxia | | | | | | | |
| Due to (or as a consequence of): | | | | | | | |
| c. | | | | | | | |
| Due to (or as a consequence of): | | | | | | | |
| d. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier Pankaj Lal | | | | 29c. License number D 39671 | | 29d. Date signed (Month, Day, Year) August 5, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pankaj Lal, M.D., 11119 Rockville Pike #100, Rockville, Maryland 20852-3143 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 10 1999 | | | | 32. Registrar's Signature Geneva B. Sparks | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26517

| | | | | | |
|---|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Richard L Brown | | 2. Date of Death Month August Day 18 Year 1999 | | 3. Time of Death 9:58 AM |
| | 4a. Facility Name (If not institution, give street and number) Baltimore Rehabilitation & Extended Care | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death n/a |
| Funeral Director | 5. Social Security Number 369-16-7211 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months 06 Days 24 Hours 19 Min. | 8. Date of Birth (Month, Day, Year) 06/24/1918 |
| | 9. Birthplace (State or Foreign Country) Michigan | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10c. City, Town or Location Timonium | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. State MD | 10b. County Baltimore | | | |
| | 10e. Street and Number 130 Springside Drive | | 10f. Zip Code 21093 | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Collega (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bakery Engineer | | 16b. Kind of Business/Industry Manufacturing |
| | 17. Father's Name (First, Middle, Last) R. Leo Brown | | 18. Mother's Name (First, Middle, Maiden Surname) Marie Rose Amberg | | |
| | 19e. Informant's Name/Relationship (Type, Print) Mrs. Mary Ann Brown/wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 Springside Drive Timonium, Maryland 21093 | | |
| | 20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Serv. Corp. | | 20c. Location - City or Town, State 08/20/1999 Towson, Maryland |
| | 21. Signature of Funeral Service Licensee Stephen D. Coster | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc 1050 York Road Towson, Maryland 21204 | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) e. Multi infarction Dementia | | Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 2 years |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Due to (or as a consequence of): | | |
| | | | Due to (or as a consequence of): | | |
| | | | Due to (or as a consequence of): | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | 28b. Time of injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Ray Calvin MD | | | 29c. License number D0032548 |
| 29d. Date signed (Month, Day, Year) August 18, 1999 | | 29e. Name and address of person who completed cause of death (Item 23e) (Type, Print) Baltimore VA Medical Center 10N. Greene St. Baltimore | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature James G. Sparks | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26518

| | | | | | | | | | |
|--|---|--|--|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) THOMAS J. BROWN | | | | 2. Date of Death Month 8 Day 22 Year 99 | | 3. Time of Death 6:35 PM | | |
| | 4a. Facility Name (If not institution, give street and number) BOX SECOURS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death NIA | | |
| Funeral Director | 5. Social Security Number 224-38-0765 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth Month 11 Day 29 Year 1932 | | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State MD | | 10b. County NIA | | 10c. City, Town or Location Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 919 N. Franklinton Rd. | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian | | 16b. Kind of Business/Industry Government | | 17. Father's Name (First, Middle, Last) John Brown | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Jones | |
| 19a. Informant's Name/Relationship (Type, Print) Beatrice Brown | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 919 N. Franklinton Rd. Balto, MD 21216 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Cemetery | | 20c. Location - City or Town, State 8-27-99 Owings Mills, MD | |
| 21. Signature of Funeral Service Licensee | | 21. Name and Address of Facility Gary E. March Funeral Home, P.A. 2410 Fredrickson Pass, Balto., MD 21229 | | 23a. Part I. Specify the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line. a. STROKE Due to (or as a consequence of): b. INTRAVASCULAR COAGULOPATHY Due to (or as a consequence of): c. RENAL FAILURE Due to (or as a consequence of): d. DIABETES MELLITUS | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Theresa R. Cruz | | 29c. License number 50030355 | | 29d. Date signed (Month, Day, Year) 8/22/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rosita R. Cruz M.D. BOX SECOURS HOSPITAL | | 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 26519**
Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|----|------------------------------------|--|----------------------------------|--|----|--|----------------------------------|--|----|--|--|----------------------------------|--|--|----|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Sterling Bower, Sr. | | | | 2. Date of Death Month Day Year Aug. 20, 1999 | | 3. Time of Death 11:50 AM | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 7415 Belmont Avenue | | | | 4b. City, Town, or Location of Death Dundalk | | 4c. County of Death Baltimore | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 179-18-4280 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 | | 8. Date of Birth (Month, Day, Year) Aug. 7, 1921 | | | | | | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) Pennsylvania | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Dundalk | | | | | | | | | | | | | | | | | | | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 7415 Belmont Avenue | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? | | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: W.W.II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Master Sergeant | | 16b. Kind of Business/Industry U.S. Air Force | | | | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Sherman Bower | | | | 18. Mother's Name (First, Middle, Maiden Surname) Cora Hess | | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Helen S. Bower (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7415 Belmont Road Baltimore, Maryland 21222 | | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. 8/23/ 1999 | | 20c. Location - City or Town, State Towson, Maryland | | | | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee Johnny L. Glades | | | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Baltimore, Maryland 21222 | | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Intermittent Bladder Cancer</td> <td rowspan="4"> Approximate Interval Between Onset and Death 1 1/2 years </td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Intermittent Bladder Cancer | Approximate Interval Between Onset and Death 1 1/2 years | Due to (or as a consequence of): | | b. | | Due to (or as a consequence of): | | c. | | | Due to (or as a consequence of): | | | d. | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Intermittent Bladder Cancer | Approximate Interval Between Onset and Death 1 1/2 years | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier M. Purcell M.D. physician | | | | 29c. License number D19714 | | 29d. Date signed (Month, Day, Year) 8/20/99 | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILWAUKEE RURAL HOSPITAL 4940 EAGLE AVE BALTIMORE, MD 21224 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature James B. Sparks | | | | | | | | | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26520

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Arville Odell Blevins

2. Date of Death
Month Day Year

August 21 1999

3. Time of Death

1423

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Emergency Department

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-16-8297

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 16, 1925

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7435 Blevins Avenue

10f. Zip Code

21219

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1945-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Not Known

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Quality Control

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

Timothy T. Blevins

18. Mother's Name (First, Middle, Maiden Summa)

Bessie Ashley

19a. Informant's Name/Relationship (Type, Print)

Son
Mr. Orville O. Blevins

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1334 Spring Ave. Baltimore, Maryland 21237

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Oak Lawn Mausoleum 8/25/1999

Data

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

John L. Sparks

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. massive intracerebral hemorrhage

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. hypertension

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

hypercholesterolemia

esophagitis, duodenitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jon Mark Hirshon

29c. License number

D44264

29d. Date signed (Month, Day, Year)

August 21 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jon Mark Hirshon Johns Hopkins Bayview Emergency Department

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

Brenda S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

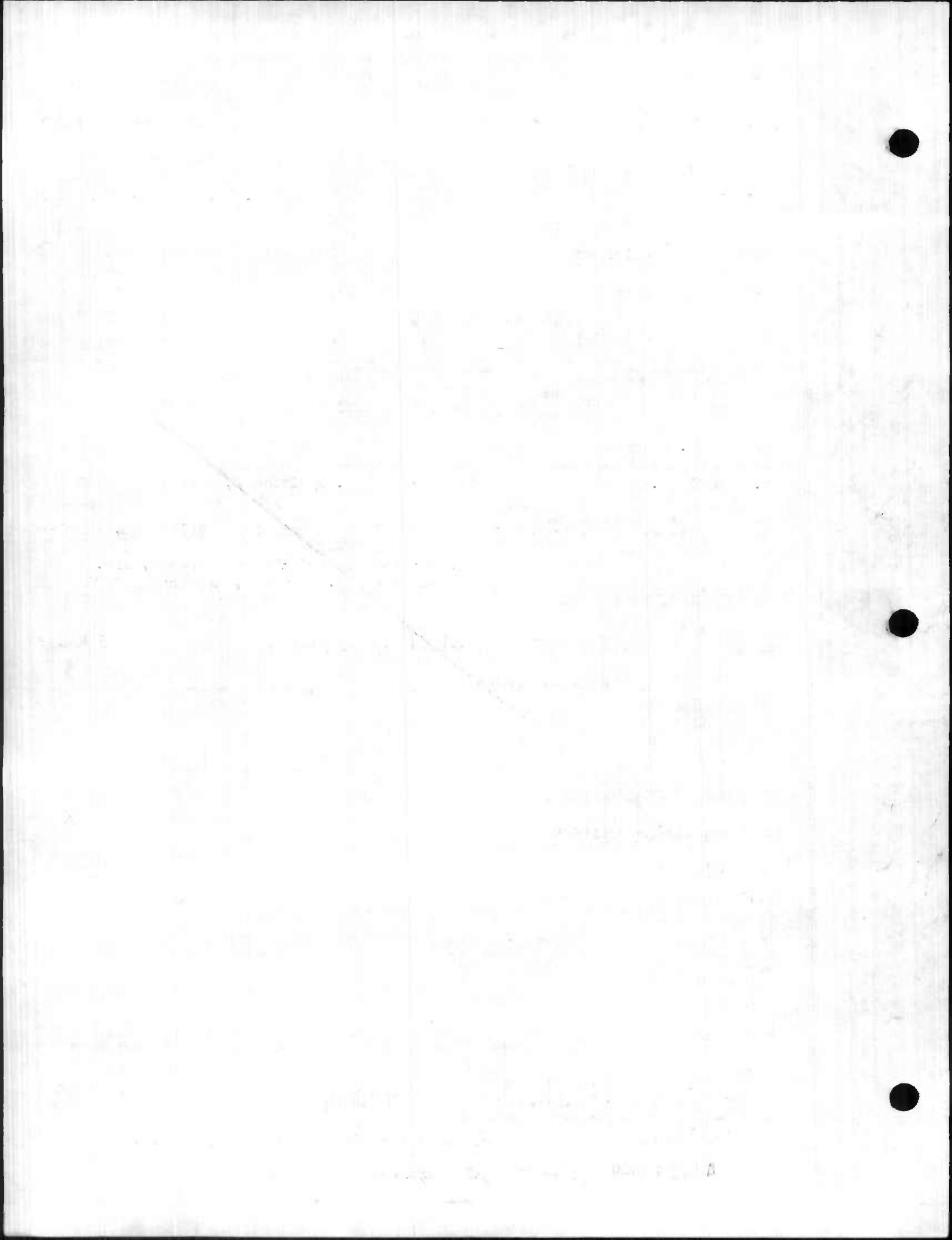
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26521

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy L. Barnes

2. Date of Death

August 20, 1999

3. Time of Death

12:30PM

4a. Facility Name (If not institution, give street and number)

Harbor Inn Convalescent Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-26-1937

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 2, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3122 Chesterfield Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Harrison Boyd

18. Mother's Name (First, Middle, Maiden Surname)

Eva Sindell

19a. Informant's Name/Relationship (Type, Print)

Edward L. Boyd (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

209 Ridgefield Road, Lutherville, Md. 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Druid Ridge

Date

8/23/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

B. C. Weller

22. Name and Address of Facility

Schimunek Funeral Home Inc.
3331 Brehms Lane, Baltimore, Maryland 2121323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of)

2 WKS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Atherosclerotic cerebrovascular

Due to (or as a consequence of)

c. disease

Due to (or as a consequence of)

d. Hypothyroidism

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Schizophrenia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Amatun N Naeem MD

29c. License number

D 15503

29d. Date signed (Month, Day, Year)

August, 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMATUN N NAEEM, 501 Dolphin St, Balto MD 21217

State
Registrar

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

B. B. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Dorothy Barnes
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26522

| | | | | | | | | |
|--|---|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Catherine Boyle | | | | 2. Date of Death Month August Day 22 Year 1999 | | 3. Time of Death 1700 hrs. | |
| | 4a. Facility Name (If not institution, give street and number) University of Maryland Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore City | |
| Funeral Director | 5. Social Security Number 210-22-5000 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 69 Yrs. | | 8. Date of Birth (Month, Day, Year) May 24, 1930 | |
| | 9. Birthplace (State or Foreign Country) Pennsylvania | | 10a. State Delaware | | 10b. County Sussex | | 10c. City, Town or Location Laurel | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 45 Shiloh Farms | | 10f. Zip Code 19956 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chambermaid | | 16b. Kind of Business/Industry Motel | | | |
| | 17. Father's Name (First, Middle, Last) Emil Nahm | | | | 18. Mother's Name (First, Middle, Maiden Surname) Catherine Johanson | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Thomas Boyle (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45 Shiloh Farms, Laurel, Delaware 19956 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cape May County Crematory | | 20c. Location - City or Town, State 8/27/99 Lower Twp., NJ | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Road, Baltimore, MD 21236 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hepatic Encephalopathy Due to (or as a consequence of): b. End Stage Liver Disease Due to (or as a consequence of): c. Cirrhosis Due to (or as a consequence of): d. Approximate interval Between Onset and Death 1 week 4 months 1 year | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis, Respiratory Failure. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier MD | | | | 29c. License number P12500 | | 29d. Date signed (Month, Day, Year) August 22, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hugo A. Torres, M.D. University of Maryland Hospital - Baltimore, MD. | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

copy of my collection

99-184 UNK
99-4827-510

asp
ANTWAN D. BROWN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26523

| | | | | | | | | |
|---|---|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Antwan D. Brown | | | | 2. Date of Death Month Day Year AUGUST 18 1999 | | 3. Time of Death 3:46 A | |
| | 4a. Facility Name (If not institution, give street and number) 2000 BLK GUILFORD AVE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 216-96-0059 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 18 Yrs. | | 8. Date of Birth (Month, Day, Year) 10-22-80 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 2414 Barclay Street | | 10f. Zip Code 21218 | | |
| 10g. Citizen of What Country? USA | | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (14 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unemployed | | 16b. Kind of Business/Industry never-worked | | |
| 17. Father's Name (First, Middle, Last) William Sturgis | | | | 18. Mother's Name (First, Middle, Maiden Surname) Cinnette Brown | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Delores McCready | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2414 Barclay Street Baltimore, Maryland 21218 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery | | 20c. Date 08-25-99 | | 20d. Location - City or Town, State Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. MULTIPLE GUNSHOT WOUNDS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death MINUTES | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| | | | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 8/18/99 | | 28b. Time of Injury 4 M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred FOUND SHOT | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2000 Block of Guilford | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) AUGUST 18, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMIA LER 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature | | | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #23 PART I, PER MEO G774 8-24-99 WR.

Certificate of Death

Reg. No. 99 26524

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Busick

2. Date of Death
Month Day Year

August 15 1999 0445 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Baltimore Veterans Administration Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

217 16 0123

6. Sex

M ☒ F ☐

7. Age (in yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Feb. 18, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

College Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4607 Norwich Rd.

10f. Zip Code

20740

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
5

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Joseph

Busick

18. Mother's Name (First, Middle, Maiden Summa)

(Unknown)

19a. Informant's Name/Relationship (Type, Print)

Joyce J. Abe / Grand Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4607 Norwich Rd., College Park, MD 20740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory 8/17/99

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Stephen D. Lohrmann

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Septicemia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. pneumonia
Due to (or as a consequence of):

10 days

c. BOWEL OBSTRUCTION

TWENTY DAYS

d. Due to (or as a consequence of):

bowel obstruction

twenty days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

acute renal failure

acute liver failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

2 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 8 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Christopher Gannon MD

29c. License number

P09758

29d. Date signed (Month, Day, Year)

August 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher Gannon 22 South Greene Street Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

Anna B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26525

| | | | | | | | | | | |
|--|--|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) NATHANIEL BRANCH | | | | 2. Date of Death Month Day Year 08 23 99 | | | | 3. Time of Death 0204 | |
| | 4a. Facility Name (If not institution, give street and number) MERCY HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 240-72-6476 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 52 Yrs. | | 8. Date of Birth (Month, Day, Year) 4/2/47 | | 9. Birthplace (State or Foreign Country) N.C. | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md. | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 408 N. Robinson St. | | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? U.S. A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11th N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver | | | | 16b. Kind of Business/Industry Yellow Van Service | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) McKinsley Branch | | | | 18. Mother's Name (First, Middle, Maiden Surname) Beatrice Branch | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) LaGrant Branch | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 N. Robinson St. Baltimore, Md. 21224 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Memorial | | Date 8/27/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee [Signature] | | 22. Name and Address of Facility Betts Funeral Home 1129 N. Caroline St. Baltimore, Md. 21213 | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. INTRA CRANIAL HEMORRHAGE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION END STAGE RENAL DISEASE | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier Jose J. Costa, MD | | | | 29c. License number D42634 | | | | 29d. Date signed (Month, Day, Year) AUG 23 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUSAN COSTA, MD 301 ST PAUL PLACE BALTIMORE MD 21202 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature [Signature] | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

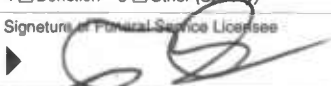
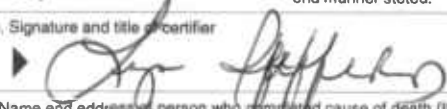
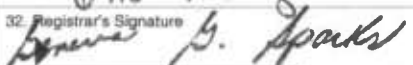
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26526

| | | | | | | | | |
|---|---|---|---|---|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BEATRICE BUETTNER | | | | 2. Date of Death Month AUGUST Day 20 Year 1999 | | 3. Time of Death 7:30 pm | |
| | 4e. Facility Name (If not institution, give street and number) 1123 ROSEDALE AVENUE | | | | 4b. City, Town, or Location of Death ROSEDALE | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 213 20 5021 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 74 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) DEC 19 1924 | 9. Birthplace (State or Foreign Country) MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location ROSEDALE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 1123 ROSEDALE AVENUE | | | | 10f. Zip Code 21237 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0 | | | | 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | |
| | 17. Father's Name (First, Middle, Last) JOHN BURKE | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARY PORACH | | | |
| | 19e. Informant's Name/Relationship (Type, Print) ROBERT BUETTNER / HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1123 ROSEDALE AVENUE ROSEDALE, MD 21237 | | | |
| | 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS OF FAITH | | Date 8/25/99 | | 20c. Location - City or Town, State BALTIMORE, MD | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTIMORE, MD 21237 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death) e. Acute Cerebrovascular Event Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension CVA - old | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D35410 | | 29d. Date signed (Month, Day, Year) Aug 23, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Liya Rappaport 6918 Ridge Rd Balto, MD 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26527

| | | | | | | | | |
|--|---|---|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Richard V. Blunt | | | | 2. Date of Death Month August Day 16 Year 1999 | | 3. Time of Death 2:30 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) 2019 W. Saratoga St. | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 213-07-2553 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 15 1907 | |
| | 9. Birthplace (State or Foreign Country) VA | | 10a. State MD | | 10b. County NIA | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2019 W. Saratoga St. | | 10f. Zip Code 21223 | | 10g. Citizen of What Country? U.S.A | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0th grade College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) longshoreman | | 16b. Kind of Business/Industry Waterfront | | | | |
| 17. Father's Name (First, Middle, Last) Unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname) Hula Hall | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Deborah Joy - Gr. Daugh. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 825 E. Coldspring Lane Balto, Md 21212 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington Park | | 20c. Location - City or Town, State Balto. Md | | 20d. Date 8/19/99 | | |
| 21. Signature of Funeral Service Licensee Phyllis B. Harris | | | | 22. Name and Address of Facility 4300 Wabash Avenue Balto, Md 21215 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Phyllis B. Harris | | | | 29c. License number D26880 | | 29d. Date signed (Month, Day, Year) 8/23/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry A. Harris 300 Armory Place Balt. Md. 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature James B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26528

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomasine L. Barnes

2. Date of Death

August 20 1999

3. Time of Death

12:50am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

216-54-4264

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12 27 46

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State
md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4803 CROWSON AVE

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12 College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

own Home

17. Father's Name (First, Middle, Last)

Spencer L. Robertson

18. Mother's Name (First, Middle, Maiden Surname)

Mattie L. Farley

19a. Informant's Name/Relationship (Type, Print)

Miss Pamela Barnes

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2815 Essex Rd. Baltimore, Md. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Voshell Mem. Garden

Date

9/2/99

20c. Location - City or Town, State

Dundalk, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bilateral Cerebrovascular accident

3 days

Due to (or as a consequence of):

b. Prolonged Hypotension & Pneumonia (TRP)

4 days

Due to (or as a consequence of):

c. Pneumonia

5 days

Due to (or as a consequence of):

d. HIV

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Paul H. Jones MD

29c. License number

AT 2438946 C12

29d. Date signed (Month, Day, Year)

Aug 20 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ricardo de Jesus Union Memorial Hospital Baltimore MD 21218

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

Jennifer G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

A142

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26529

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Paul M. Brooks

2. Date of Death

Month Day Year
August 19, 1999

3. Time of Death

4:20 PM

4a. Facility Name (If not institution, give street and number)

The Keswick Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-01-7700

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan 11, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3838 Roland Avenue

Apt 903

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Rprinter

16b. Kind of Business/Industry

Printing

17. Father's Name (First, Middle, Last)

William Henry Brooks

18. Mother's Name (First, Middle, Maiden Surname)

Nona Breashears

19a. Informant's Name/Relationship (Type, Print)

Geraldine Brooks (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3838 Roland Avenue Apt 903, Baltimore, Maryland 21211

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial

Date

8/23/99

20c. Location - City or Town, State

Dorsey, Maryland

21. Signature of Funeral Service Licensee

Lepp B. Hones

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road, Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Pneumonia*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Shy-Drager's Syndrome

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joseph W. Sparks

29c. License number

D-22334

29d. Date signed (Month, Day, Year)

8/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEBLEY, Joseph 400 W 70th Street BALTIMORE 21211

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

Joseph W. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26530

AMEND #10f & 19a PER F.H. 8775 9-3-99 J.A.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

| | | | | | | | |
|---|--|--|---|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Thomas Richard Coleman | | | | 2. Date of Death August 21, 1999 | | 3. Time of Death 3:13 AM | |
| 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | |
| 5. Social Security Number 213-03-7247 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 9 1912 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD. | | 10b. County Baltimore | | 10c. City, Town or Location Towson | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 28 West Allegheny Ave #1904 | | | | 10f. Zip Code 21294 21204 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager | | 16b. Kind of Business/Industry Printing | |
| 17. Father's Name (First, Middle, Last) Nelson Reynolds Coleman | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mattie Colenothy Shaw | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ms. Tracy L. Price/GDTR | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Ayr Court Baltimore, MD. 21236 | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Co. | | Date 8-23-99 | | 20c. Location - City or Town, State Towson, MD. | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 | | | |

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D-30263 | | 29d. Date signed (Month, Day, Year) 8-21-99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) FRANCIS KHOO M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 | | | | | |

State
Registrar

31. Date filed (Month, Day, Year)
AUG 24 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

5+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26531

AMEND ITEM: #17, 18 Per F.H. G774 8-24-99 WR

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) CARMINA C. CRAMER | | | | 2. Date of Death Month August Day 19 Year 1999 | | 3. Time of Death 1:30 P.M. | |
| 4a. Facility Name (If not institution, give street and number) 821 BARBARA COURT | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death ANNE ARUNDEL CO. | |
| 5. Social Security Number 155-10-8909 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 21 1920 | |
| 9. Birthplace (State or Foreign Country) New Jersey | | | | | | | |
| 10a. State Md. | | 10b. County Anne Arundel Co. | | 10c. City, Town or Location Glen Burnie | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 821 Barbara Court | | | | 10f. Zip Code 21060 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Home Owner | |
| 17. Father's Name (First, Middle, Last) Sylvio Bizzario BIZZARIO | | | | 18. Mother's Name (First, Middle, Maiden Surname) Augusta Cuccagna AGUSTA | | | |
| 19a. Informant's Name/Relationship (Type, Print) Cathy Stein (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 702 211th Street, Pasadena, Md. 21122 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park | | 20c. Location - City or Town, State 8/23/99 Glen Burnie, Md. | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122 | | | |

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3 MONTH! | | | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D21776 | | 29d. Date signed (Month, Day, Year) AUGUST 20 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUREA P. MUNISRA MD 3001 S HANOVER ST BALTIMORE 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature | | | | | |

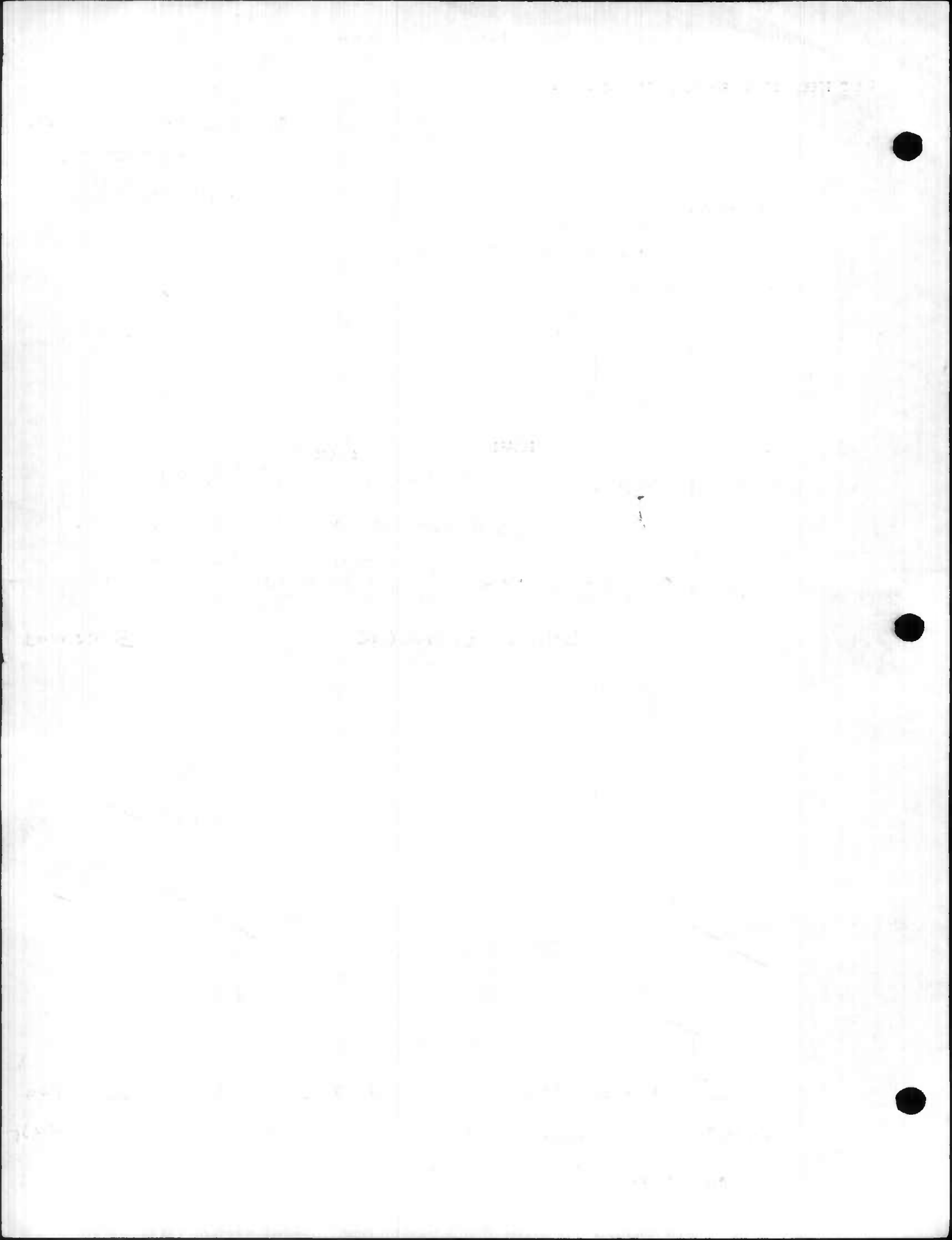
Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26532

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Carol Crockett | | | | 2. Date of Death Month August Day 22 Year 1999 | | 3. Time of Death 7:27 AM | |
| | 4a. Facility Name (If not institution, give street and number) University of Maryland | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 220-80-2804 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 36 Yrs. | | 8. Date of Birth (Month, Day, Year) 11-03-63 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 701 WALNUT AVENUE | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) GED | | College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC | | 16b. Kind of Business/Industry Home | | |
| 17. Father's Name (First, Middle, Last) CALVIN SLOWE | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARY CROCKETT | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MARY CROCKETT MOTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 LEAFDALE TERR. BALTO. MD. 21208 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY | | 20c. Date 8-28-99 | | 20d. Location - City or Town, State BALTO. MD | | |
| 21. Signature of Funeral Service Licensee Vaughn C. Greene | | | | 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NAT'L PIKE, BALTO. MD. 21229 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Interventricular Hemorrhage Due to (or as a consequence of): b. Intracranial Bleed Due to (or as a consequence of): c. Herniation of Brain Due to (or as a consequence of): d. Cerebellar AVM | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HIV | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Dr. H. H. H. | | | | 29c. License number AU4176435512457 | | 29d. Date signed (Month, Day, Year) August 23 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nirav Shah 22 S. Greene Street 12th Floor Baltimore | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26533

| | | | | | | | | | |
|---|---|--|---|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Darlene Capers | | | | 2. Date of Death Month Day Year August 20, 1999 | | 3. Time of Death 6:00 a.m. | | |
| | 4a. Facility Name (If not institution, give street and number) 2130 N. Pulaski Street | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 249-68-8646 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 58 Yrs. | | 8. Date of Birth (Month, Day, Year) 8 10 1941 | | |
| | 9. Birthplace (State or Foreign Country) S.C. | | 10a. State Md | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number 2130 N. Pulaski Street | | | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? U S A | | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nutrition | | 16b. Kind of Business/Industry Johns Hopkins Hospital | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Arthur Robinson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Unk Verniea | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Michael Lee- Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2130 N. Pulaski Street Baltimore, Md 21217 | | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Pine Grove A. M. E. Ch | | 20c. Location - City or Town, State 8-28-99 Newberry Co, S.C. | | | | |
| | 21. Signature of Funeral Service Licensee Bladys Wane | | 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. myocardial Infarction Due to (or as a consequence of): b. Diabetes mellitus Due to (or as a consequence of): c. Obesity Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Seizure Disorder | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| | 29b. Signature and title of certifier Norman D Anderson MD | | 29c. License number D16101 | | 29d. Date signed (Month, Day, Year) Aug 23, 1999 | | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Norman D Anderson, Johns Hopkins Hospital, Baltimore MD 21205 | | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature James B. Sparks | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26534

| | | | | | | | | | | | |
|---|--|--|---|---|--|---|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Ronald W. Carruthers, Sr.</u> | | | | | 2. Date of Death Month <u>Aug</u> Day <u>20</u> Year <u>1999</u> | | 3. Time of Death <u>4:00 pm</u> | | | |
| | 4a. Facility Name (If not institution, give street and number) <u>4-B Lockhart Circle</u> | | | | | 4b. City, Town, or Location of Death <u>Forest Hill</u> | | 4c. County of Death <u>Harford</u> | | | |
| Funeral Director | 5. Social Security Number <u>218-28-4555</u> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>67</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>Feb 24, 1932</u> | | 9. Birthplace (State or Foreign Country) <u>Maryland</u> | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | | 10a. State <u>Md</u> | | 10b. County <u>Harford</u> | | 10c. City, Town or Location <u>Forest Hill</u> | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | 10e. Street and Number <u>4-B Lockhart Circle</u> | | | | 10f. Zip Code <u>21050</u> | | 10g. Citizen of What Country? <u>USA</u> | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>2</u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>electrical engineer</u> | | | 16b. Kind of Business/Industry <u>Johns Hopkins A.P.L.</u> | | | | |
| 17. Father's Name (First, Middle, Last) <u>UNKNOWN</u> | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Marie Kelly</u> | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Ruth K. Fisher</u> | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>900 N. Rural Rd. Apt. 2073 Chandler, AZ 85226</u> | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Dulaney Valley Mem. Gdns.</u> | | | Date <u>Aug 24 1999</u> | | 20c. Location - City or Town, State <u>Timonium, Maryland</u> | | | |
| 21. Signature of Funeral Service Licensee <u>Krista S. Uelle</u> | | | | | | 22. Name and Address of Facility <u>EVANS FUNERAL CHAPEL - BELTIR</u> <u>3 Newport Dr. Forest Hill, Md 21050</u> | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) a. <u>ASCVD</u> Due to (or as a consequence of): | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): | | | | | | | | | | | |
| c. _____ Due to (or as a consequence of): | | | | | | | | | | | |
| d. _____ Due to (or as a consequence of): | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier <u>[Signature]</u> DME | | | | | | 29c. License number <u>OCME</u> | | 29d. Date signed (Month, Day, Year) <u>Aug 20 99</u> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Dr. Harash Prabhku 218 Fulford Ave. Bel Air, Md.</u> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>AUG 24 1999</u> | | | | 32. Registrar's Signature <u>[Signature]</u> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

4H10

ORIGINAL

WRC
99-4708-510
VERNON
CROWFFEY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26535

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Vernon E. Crowffey Sr. | | | | 2. Date of Death Month Day Year AUGUST 14, 1999 | | 3. Time of Death 5:15 PM. | |
| | 4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 218-42-3395 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 53 Yrs. | | 8. Date of Birth (Month, Day, Year) July 29, 1946 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3822 Kimble Rd. | | 10f. Zip Code 21218 | | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. African American | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian | | 16b. Kind of Business/Industry Maintenance | | |
| 17. Father's Name (First, Middle, Last) Nathan Crowffey | | 18. Mother's Name (First, Middle, Maiden Surname) Maddie Pope | | 19a. Informant's Name/Relationship (Type, Print) Mrs. Estella English Crowffey (wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3822 Kimble Rd. Balto. Md. 21218 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory | | 20c. Location - City or Town, State 8/24/99 Baltimore, Md. | | 21. Signature of Funeral Service Licensee Joseph L. Russ | | |
| 22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216 | | 23a. Path. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hypertensive atherosclerotic cardiovascular disease | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number O.C.M.E. | | |
| 29d. Date signed (Month, Day, Year) AUGUST 15, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ann Dixon | | 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature [Signature] | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26536

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Gilbert John Chuhean</i> | | | | 2. Date of Death Month <i>August</i> Day <i>18</i> Year <i>1999</i> | | 3. Time of Death <i>11:12pm</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>Howard County General Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Columbia</i> | | 4c. County of Death <i>Howard</i> | |
| Funeral Director | 5. Social Security Number <i>183-12-3829</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>84</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>July 12 1915</i> | 9. Birthplace (State or Foreign Country) <i>Pennsylvania</i> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State <i>Md</i> | | 10b. County <i>Howard</i> | | 10c. City, Town or Location <i>Columbia</i> | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number <i>6333 Sun High Place</i> | | | | 10f. Zip Code <i>21045</i> | | 10g. Citizen of What Country? <i>USA</i> | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>unknown</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Chemist</i> | | | 16b. Kind of Business/Industry <i>Martin Marietta</i> | |
| 17. Father's Name (First, Middle, Last) <i>George Chuhean</i> | | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Anna Reich</i> | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Ruby Chuhean wife</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6333 Sun High Place Columbia, Md 21045</i> | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Dulany Valley Mem. Gdn.</i> | | 20c. Location - City or Town, State <i>Timonium, Maryland</i> | | Date <i>Aug. 21 1999</i> |
| 21. Signature of Funeral Service Licensee <i>Keisha S. Wells</i> | | | | 22. Name and Address of Facility <i>EVANS FUNERAL CHAPEL 8800 Harford Rd. Baltimore, Md 21234</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>coronary artery disease</i> Due to (or as a consequence of): b. <i>congestive heart failure</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death <i>10 years</i> <i>3 years</i> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Darryl Miller MD</i> | | 29c. License number <i>D26621</i> | | 29d. Date signed (Month, Day, Year) <i>August 19, 1999</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dr. Darryl Miller 3460 Ellicott Center Dr. Suite 103 Ellicott City, Md.</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>AUG 24 1999</i> | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AH 10

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26537

AMEND#10c, 10e & 10f PER F.H. G775 9-1-99 J. **Certificate of Death**

Reg. No.

| | | | | | |
|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ETHEL DRONEBURG | | 2. Date of Death Month August Day 18 Year 1999 | | 3. Time of Death 0310 AM |
| | 4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 217-22-1898 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 83 Yrs. | 8. Date of Birth (Month, Day, Year) June 9, 1916 | |
| | 9. Birthplace (State or Foreign Country) N.C. | | | | |
| To Be Completed by Funeral Director | 10a. State MD. | | 10b. County Baltimore | | 10c. City, Town or Location TOWSON |
| | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number 10 Decatur Rd. | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist | | 16b. Kind of Business/Industry Black & Decker |
| | 17. Father's Name (First, Middle, Last) John H. Durham | | 18. Mother's Name (First, Middle, Maiden Surname) Ophelia Hamm | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mr. Clyde T. Droneburg, Jr./son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Decatur Rd. Baltimore, MD. 21220 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial | | 20c. Location - City or Town, State Timonium, MD. |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) Sepsis | | | | < 1 week |
| | Due to (or as a consequence of): Cellulitis | | | | 1 month |
| | Due to (or as a consequence of): | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23a. Part II. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| State Registrar | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5601 Loch Raven Blvd Baltimore, MD 21239 | | |
| State Registrar | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier Physician | | 29c. License number D0054303 | | |
| | 29d. Date signed (Month, Day, Year) August 18, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Z.A. Eidadah Good Samaritan Hospital | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

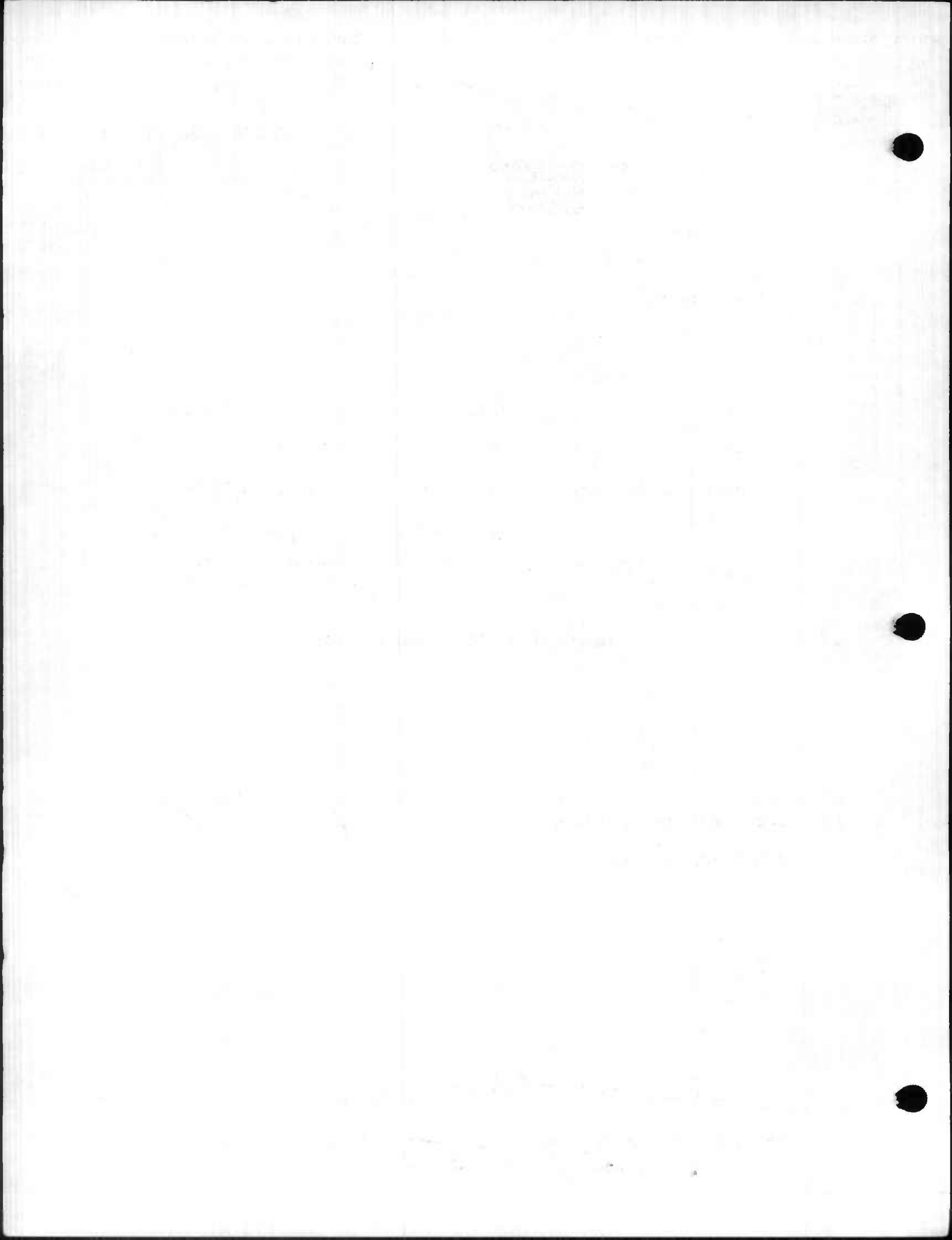
Reg. No.

99 26538

| | | | | | |
|---|--|--|--|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARTIN BISSET DODD | | 2. Date of Death Month AUGUST Day 22 Year 1999 | | 3. Time of Death 7:43 PM |
| | 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore |
| Funeral Director | 5. Social Security Number 216-07-8138 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 80 Yrs. | If Under 1 Year Months Days | 8. Date of Birth (Month, Day, Year) Dec. 22, 1918 |
| | 9. Birthplace (State or Foreign Country) Md. | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10e. State Md. | | 10b. County Baltimore |
| | 10c. City, Town or Location Towson | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 1643 Mussula Rd. | | 10f. Zip Code 21286 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW-II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer |
| | 16b. Kind of Business/Industry Westinghouse | | 17. Father's Name (First, Middle, Last) William Dodd | | 18. Mother's Name (First, Middle, Maiden Surname) Virginia Smith |
| | 19a. Informant's Name/Relationship (Type, Print) Mrs. Jeanne G. Dodd/wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1643 Mussula Rd. Towson, Md. 21286 | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. | | Date 8/26/99 |
| | 20c. Location - City or Town, State Towson, MD. | | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GASTROINTESTINAL BLEEDING ATELECTASIS OF LUNG | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | |
| 28b. Time of Injury M | | | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 28d. Describe how Injury occurred | | | | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier | | | | | |
| 29c. License number D-30263 | | | | | |
| 29d. Date signed (Month, Day, Year) 8-22-99 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | | |
| 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26539

| | | | | | | | | | | | |
|---|---|---|--|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Carmella Mary DeRicco | | | | | | 2. Date of Death Month Day Year August 18 1999 | | 3. Time of Death 4:50 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number) Mariner Health of Forest Hill | | | | | | 4b. City, Town, or Location of Death Forest Hill | | 4c. County of Death Harford | | |
| Funeral Director | 5. Social Security Number 104-01-5602 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) April 12, 1919 | | 9. Birthplace (State or Foreign Country) New York | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Bel Air | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number 812 N. Pine Ridge Court | | | | 10f. Zip Code 21014 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th grade College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telephone Operator | | | 16b. Kind of Business/Industry Phone Co. | | | | |
| 17. Father's Name (First, Middle, Last) Frank Laudanno | | | | | | 18. Mother's Name (First, Middle, Maiden Summa) Anna Cappetta | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Josephine D'Anna (Sister) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 812 N. Pine Ridge Court, Bel Air, MD. 21014 | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Florida National Cem. | | 20c. Date 8/23/99 | | 20d. Location - City or Town, State Bushnell, Florida | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Parkinson's disease</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | | | | Approximate Interval Between Onset and Death 22 years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number D32299 | | | |
| | | | | 29d. Date signed (Month, Day, Year) August 17, 1999 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David S. Dunne 615 W. MacPhail Rd. | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26540

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH DAVIS

2. Date of Death
Month Day Year

08 20 1999

3. Time of Death

2:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HOMWOOD CENTER GENESIS ELDERCARE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

217-20-8000

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 7, 1903

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

H/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

401 BOKEL COURT

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 years

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home maker

18b. Kind of Business/Industry

Private family

17. Father's Name (First, Middle, Last)

JOHN Wesley Smith

18. Mother's Name (First, Middle, Maiden Surname)

EMMA WALKINS

19a. Informant's Name/Relationship (Type, Print)

Connie R. Carter / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

401 BOKEL COURT Baltimore, Maryland 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pleasant Rest Cemetery

Date

8/24/99

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CHARTER - HARRIS F.H. 5240 REISTERSTOWN ROAD BALTIMORE, Maryland 21115

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Silent Arrhythmia

Approximate Interval Between Onset and Death

minutes

a.

Due to (or as a consequence of):

b.

Congestive Heart Failure

Due to (or as a consequence of):

years

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism

dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

Medical

Asst. Dir.

29c. License number

D17118

29d. Date signed (Month, Day, Year)

8/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Schwartz M.D. 105 McKeown Ave 21212

State
Registrar

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

The first part of the paper
 is devoted to a general
 discussion of the
 problem. It is shown that
 the problem is of great
 importance in the theory
 of the differential equations
 of the second order.

Chapter I. General
 properties of the



and the second part
 is devoted to a detailed
 study of the problem.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26541

| | | | | | | | | |
|---|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Howard A. Dorsey | | | | 2. Date of Death Month Day Year August 19, 1999 | | 3. Time of Death 1:00 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) 1718 Glen Keith Blvd | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Balto | |
| Funeral Director | 5. Social Security Number 212-30-3446 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) 12-31-1932 | |
| | 9. Birthplace (State or Foreign Country) Md | | 10a. State Md | | 10b. County Balto | | 10c. City, Town or Location Towson | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 1718 Glen Keith Blvd | | 10f. Zip Code 21286 | | 10g. Citizen of What Country? U.S.A | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) G.E.D. College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | 16b. Kind of Business/Industry Mid Atlantic | | | | |
| 17. Father's Name (First, Middle, Last) Herman Dorsey | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elease Burgess | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mark Dorsey - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9046 Tarpley 21237 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet | | Date 8/25/99 | | 20c. Location - City or Town, State Owings Mills, Md | | |
| 21. Signature of Funeral Service Licensee Bladys Wanes | | 22. Name and Address of Facility March F.H. West 21215 4300 Wabash Avenue Balto, Md | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. atherosclerotic artery disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | Approximate Interval Between Onset and Death | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Dr. H. Cummings MD | | 29c. License number P11749 | | 29d. Date signed (Month, Day, Year) 8/24/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. H. Cummings, VA Hospital, Baltimore | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature B. Spikes | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1911

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1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25518

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PETER GEORGE ENGLISH

2. Date of Death

Month Day Year
AUGUST 22, 1999 7:16 AM

3. Time of Death

Funeral
Director

4e. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

5. Social Security Number

207-50-9587

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

40

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
January 30, 1959

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5315 St Albans Way

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Stock Broker

16b. Kind of Business/Industry

Investments

17. Father's Name (First, Middle, Last)

Peter George English

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte McGinnis

19a. Informant's Name/Relationship (Type, Print)

Charlotte McG. English

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Mother 5315 St Albans Way Baltimore, Maryland 21212

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St Davids Churchyard

Date

8/26/99

20c. Location - City or Town, State

Wayne Pennsylvania

21. Signature of Funeral Service Licensee

Dennis Stephen Kenakis

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home Inc.
6500 York Road Baltimore, Maryland 2121223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Hepatic encephalopathy

Due to (or as a consequence of):

b. Endstage liver disease

Due to (or as a consequence of):

c. Alcohol-induced hepatic cirrhosis

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Acute renal failure

Subdural hemorrhage

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of causa
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

26a. Date of Injury

(Month, Day, Year)

26b. Time of
Injury

M

26c. Injury at
Work?1 ☐ Yes 2 ☐ No

26d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Wolfehead, M.D.

29c. License number

P11402

29d. Date signed (Month, Day, Year)

AUGUST 22, 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

WILLIAM IMBEAH, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD, BALTIMORE,
MD 21239

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26513

| | | | | | | | | | |
|---|---|---|--|---|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) THELMA MARIE EDWARDS | | | | 2. Date of Death Month Day Year Aug. 22, 1999 | | 3. Time of Death 10:55 a.m. | | |
| | 4a. Facility Name (If not institution, give street and number) Eastpoint Nursing Home | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 228-16-0733 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 | | 8. Date of Birth (Month, Day, Year) Aug. 27, 1918 | | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 1936 Holborn Road | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | 17. Father's Name (First, Middle, Last) Heath M. Ogle | | 18. Mother's Name (First, Middle, Maiden Surname) Bessie Cole | |
| 19a. Informant's Name/Relationship (Type, Print) Lois Adelung (Daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1936 Holborn Road, Dundalk, MD 21222 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardens | | 20c. Location - City or Town, State Bel Air, Maryland | |
| 21. Signature of Funeral Service Licensee Mark T. [Signature] | | 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Arteriosclerotic Heart Disease Due to (or as a consequence of): b. Arteriosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death > 2 yr | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number 011150 | | 29d. Date signed (Month, Day, Year) 8/23/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MELITO M TORRES MD 441 S. ELLWOOD AVE, BALTO, MD 21224 | | 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature [Signature] | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMEND#5 PER F.H. G775 9-8-99 J.A.

99 26544

Physician
/Medical
Examiner

Jack Stanton Evans

2. Date of Death
Month Day Year
August 20, 1999
3. Time of Death
3:08 AMFuneral
Director

4e. Facility Name (If not institution, give street and number)

5343 Heatherland Ct.

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

5. Social Security Number

195-42-8390

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
September 15, 1956

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5343 Heatherland Ct.

10f. Zip Code

21043

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Business Development

16b. Kind of Business/Industry

Computer

17. Father's Name (First, Middle, Last)

George A. Evans

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Ann Schirm

19a. Informant's Name/Relationship (Type, Print)

Mrs. Jennifer J. Evans Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5343 Heatherland Ct. Ellicott City, Maryland 21043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory

Date

08/20/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

A. Thomas Randall M.D.

22. Name and Address of Facility

Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 2104323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

6 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

DIRECTOR, DIVISION
OF MEDICAL ONCOLOGY

29c. License number

023675

29d. Date signed (Month, Day, Year)

8-20-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Donehower, Ross C., M.D., F.A.C.P. 600 North Wolfe St. Baltimore, MD 21287-8936

State
Registrar

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

James G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State of New York

County of ...

NEW YORK

...

250-00

250-00

...

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26545

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|---|---|--|--|--------------------|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Andrew Finney</u> | | | | 2. Date of Death Month <u>8</u> Day <u>22</u> Year <u>99</u> | | 3. Time of Death <u>9:50 pm</u> | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) <u>FUTURECARE HOMECARE 2700 N CHARLES</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>Baltimore City</u> | | | | | | | | | | |
| Funeral Director | 5. Social Security Number <u>224-28-7462</u> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>79</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>02-29-20</u> | | | | | | | | | | |
| | 10a. State <u>MD.</u> | | 10b. County <u>N/a</u> | | 10c. City, Town or Location <u>BALTIMORE</u> | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. Street and Number <u>5803 LEITHWALK</u> | | | | 10f. Zip Code <u>21239</u> | | 10g. Citizen of What Country? <u>USA</u> | | | | | | | | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u> | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>-8-</u> College (1-4or 5+) <u>-0-</u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>TRUCK DRIVER</u> | | 16b. Kind of Business/Industry <u>CONSTRUCTION</u> | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) <u>OSWALD B. FINNEY</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>PEARL PRUITT</u> | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <u>SHEILA OKPALA (DAUGHTER)</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5803 LEITHWALK BALTIMORE, MARYLAND 21239</u> | | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>GARRISON FOREST VETERANS 8-27-99</u> | | 20c. Location - City or Town, State <u>OWINGS MILLS, MARYLAND</u> | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee <u>Doretha Hector</u> <u>CFSP</u> | | | | 22. Name and Address of Facility <u>PHILLIPS FUNERAL HOME, P.A.</u> <u>1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217</u> | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4"> Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. <u>END - STAGE RENAL DISEASE</u> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <u>unknown</u></td> </tr> <tr> <td>b. <u>DIABETE MELLITUS</u> Due to (or as a consequence of):</td> <td><u>10-15 YEARS</u></td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> <td></td> </tr> </table> | | | | | | | | Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>END - STAGE RENAL DISEASE</u> Due to (or as a consequence of): | Approximate Interval Between Onset and Death <u>unknown</u> | b. <u>DIABETE MELLITUS</u> Due to (or as a consequence of): | <u>10-15 YEARS</u> | c. _____ Due to (or as a consequence of): | | d. _____ Due to (or as a consequence of): | |
| | Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>END - STAGE RENAL DISEASE</u> Due to (or as a consequence of): | Approximate Interval Between Onset and Death <u>unknown</u> | | | | | | | | | | | | | | |
| b. <u>DIABETE MELLITUS</u> Due to (or as a consequence of): | | <u>10-15 YEARS</u> | | | | | | | | | | | | | | | |
| c. _____ Due to (or as a consequence of): | | | | | | | | | | | | | | | | | |
| d. _____ Due to (or as a consequence of): | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ESSENTIAL HYPERTENSION</u> <u>CARCINOMA OF PROSTATE</u> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| | | | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <u>Komal K. Dang</u> | | | | | | | | | | | | | |
| | | | | 29c. License number <u>D18368</u> | | 29d. Date signed (Month, Day, Year) <u>8-23-1999</u> | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Komal K. Dang M.D., 3455, Wilkens Ave, Suite 308. Balto. Md 21229.</u> | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>AUG 24 1999</u> | | | | 32. Registrar's Signature <u>B. Spahr</u> | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26546

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NORRIS NR. FREEMAN

2. Date of Death

AUGUST 23 1999

3. Time of Death

1:05 Am

4a. Facility Name (If not institution, give street and number)

BON SECOUR HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-52-4043

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

3-7-25

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2505 EDMONDSON AVE.

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
-8-College (1-4or 5+)
-0-18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

GOLDIE PARKER(FRIEND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2505 EDMONDSON AVE. BALTIMORE, MARYLAND 21223

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

METRO CREMATORY

Data

8-26-99

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Dorothy Hector

22. Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.
1721-27 N. MONROE ST. BALTIMORE, MARYLAND 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Severe Dehydration
Due to (or as a consequence of):
b. Multiple Decubitus Ulcers
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastc. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Terance J. Lamb M.D.

29c. License number

D37203

29d. Date signed (Month, Day, Year)

August 23 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TERANCE LAMB M.D. Bon Secours Hospital Baltimore, MD 21223

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

B. Spahr

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26547

| | | | | | | | | | | |
|---|--|---|--|--|--|---|---------------------------------|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HUTZLER FREEMAN | | | | 2. Date of Death Month Day Year 08-19-99 | | | | 3. Time of Death 5:20 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) 5918 LEEWOOD AVENUE | | | | 4b. City, Town, or Location of Death CATONSVILLE | | | | 4c. County of Death BALTO. | |
| Funeral Director | 5. Social Security Number 213 26 9543 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 69 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) 01-15-30 | | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location CATONSVILLE | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 5918 LEEWOOD AVENUE | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHEMIST | | 16b. Kind of Business/Industry PAINT CO. | | 17. Father's Name (First, Middle, Last) WILLIAM FREEMAN | | 18. Mother's Name (First, Middle, Maiden Surname) ESTELLA HIGH | | 19a. Informant's Name/Relationship (Type, Print) JOAN FREEMAN/WIFE | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5918 LEEWOOD AVENUE CATONSVILLE, MD. 21228 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WESTERN STAR CEM. | | Date 8/26/99 | | 20c. Location - City or Town, State BALTIMORE, MD. | | |
| 21. Signature of Funeral Service Licensee <i>James A. Morton</i> | | 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST. BALTIMORE, MD. 21217 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Adenocarcinoma of Lung Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death Six Months | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Michael F. Kelly MD</i> | | 29c. License number D 50727 | | 29d. Date signed (Month, Day, Year) August 20, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael F. Kelly MD St. Agnes Hosp 900 Caton Ave Balt. MD 21229 | | 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature <i>Linnea B. Sparks</i> | | | | | | |

ORIGINAL

12-15-99 WR.
 99-4953-005 AMEND ITEM: #23 PART I 9-30-99 WR.
 mmmr AMEND ITEMS: #1 PER MEO G775 PER MEO G775 9-14-99 WR.
 Michael Gamage AMEND ITEMS: #23 PART I, 27, 28A-F

Certificate of Death

Reg. No.

99 26548

| | | | | | |
|--|---|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MICHAEL GAMAGER SR. MICHAEL DARRYL GAMAGE | | 2. Date of Death Month Day Year August 22, 1999 | | 3. Time of Death 1:13 a.m. |
| | 4a. Facility Name (If not institution, give street and number) 939 Elm Ridge Avenue | | 4b. City, Town, or Location of Death Carroll | | 4c. County of Death Baltimore |
| Funeral Director | 5. Social Security Number 487-76-2536 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 39 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) 12-13-59 | | 9. Birthplace (State or Foreign Country) MISSOURI MD | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD. | | 10b. County BALTIMORE | | 10c. City, Town or Location CARROLL | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 939 ELM RIDGE AVE. | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -11- College (1-4 or 5+) -0- | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PAINTER | | 16b. Kind of Business/Industry CONSTRUCTION | |
| 17. Father's Name (First, Middle, Last) JAMES GAMAGER | | 18. Mother's Name (First, Middle, Maiden Surname) SYLVIA KELLY | | | |
| 19a. Informant's Name/Relationship (Type, Print) SYLVIA GAMAGER (MOTHER) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 939 ELM RIDGE AVE. CARROLL, MD. 21229 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY | | 20c. Date 8-26-99 | |
| 20d. Location - City or Town, State BALTIMORE, MARYLAND | | | | | |
| 21. Signature of Funeral Service Licensee Douglas Hector CFSP | | 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE COCAINE INTOXICATION ASSOCIATED WITH ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | |
| Immediate Cause (Final disease or condition resulting in death) a. ACUTE COCAINE INTOXICATION Due to (or as a consequence of): | | | | | |
| b. Due to (or as a consequence of): | | | | | |
| c. Due to (or as a consequence of): | | | | | |
| d. Due to (or as a consequence of): | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Found: 8-22-99 | | 28b. Time of Injury Found: 1:00 | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred UNKNOWN | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 939 ELM RIDGE AVE. CARROLL, MD | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Dennis J. Chute | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) August 22, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature [Signature] | | | |

1-1-71

OFFICE OF THE ATTORNEY GENERAL

U. S. GOVERNMENT PRINTING OFFICE: 1964 O - 345-741
U. S. GOVERNMENT PRINTING OFFICE: 1964 O - 345-741

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26549

| | | | | | | | | | | |
|--|---|---|---|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Chester Miller Grove | | | | 2. Date of Death Month Day Year August 15, 1999 | | | | 3. Time of Death 4:40 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) Morningside House of Laurel | | | | 4b. City, Town, or Location of Death Laurel | | | | 4c. County of Death Prince George | |
| Funeral Director | 5. Social Security Number 578-10-8427 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) June 2, 1908 | | 9. Birthplace (State or Foreign Country) Washington, DC | | 10a. State MD | | 10b. County Prince George | | 10c. City, Town or Location Beltsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 4720 Naples Avenue | | | | 10f. Zip Code 20705 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver | | | | 16b. Kind of Business/Industry Public Transportation | |
| | 17. Father's Name (First, Middle, Last) John H. Grove | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sadie Miller | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) John R. Grove/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4720 Naples Avenue, Beltsville, Maryland 20705 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery | | Date 8/18/99 | | 20c. Location - City or Town, State Brentwood, Maryland | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 | | | | | |
| | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. HYPERCHOLESTEROLEMIA Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 2 YEARS 2 YEARS 2 YEARS | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HISTORY PROSTATE CANCER | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ASSISTED | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred LIVING | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D-25914 | | |
| 29d. Date signed (Month, Day, Year) 8/16/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALLEN BRINKLEY, MD. 12201 PLUM ORCHARD DR. SILVER SPRING, MD 20904 | | 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26550

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARJORIE

H.

GOUKER

2. Date of Death

Month

Day

Year

August 20, 1999

3. Time of Death

15:30

4a. Facility Name (If not institution, give street and number)

THE Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore, City

4c. County of Death

MD

Funeral
Director

5. Social Security Number

215-18-5483

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

APRIL 24, 1921

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

LUTHERVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10509 SAMONA ROAD

10f. Zip Code

21030

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CLERICAL

16b. Kind of Business/Industry

STATE OF MARYLAND

17. Father's Name (First, Middle, Last)

ELMORE HARGEST

18. Mother's Name (First, Middle, Maiden Surname)

ELVRIDGE HAYDEN

19a. Informant's Name/Relationship (Type, Print)

WILLIAM S. GOUKER, SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10509 SAMONA ROAD, LUTHERVILLE, MD. 21030

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DULANEY VALLEY MEM GDS

Date

AUG 24 1999

20c. Location - City or Town, State

TIMONIUM, MD

21. Signature of Funeral Service Licensee

Laura Christine Hardesty

22. Name and Address of Facility

EVANS FUNERAL CHAPEL
2325 YORK RD. TIMONIUM, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. GASTROINTESTINAL BLEEDING

FIVE DAYS

Due to (or as a consequence of):

b. END STAGE LIVER DISEASE

MONTHS

Due to (or as a consequence of):

c. AUTOIMMUNE HEPATITIS

YEARS

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J M Sizemore Jr MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

AUGUST 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES M SIZEMORE JR MD JOHNS HOPKINS HOSPITAL TOWER 110 BALTIMORE MD 21287

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

EXHIBIT

Page 100

EXHIBIT

Exhibit 100

EXHIBIT 100

EXHIBIT 100

EXHIBIT 100

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EXHIBIT 100

EXHIBIT 100

EXHIBIT 100

EXHIBIT 100

EXHIBIT 100

| | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Walter Linwood Garnett</u> | | | | 2. Date of Death Month Day Year <u>August 17, 1999</u> | | 3. Time of Death <u>12:57 P.M.</u> | | |
| | 4a. Facility Name (If not institution, give street and number) <u>4001 White Avenue, Apartment 4C</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>N/A</u> | | |
| Funeral Director | 5. Social Security Number <u>215-94-5561</u> | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>36</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>2-13-1963</u> | | |
| | 9. Birthplace (State or Foreign Country) <u>Maryland</u> | | 10a. State <u>Md.</u> | | 10b. County <u>N/A</u> | | 10c. City, Town or Location <u>Baltimore</u> | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number <u>4001 WHITE AVE. APT. 4C</u> <u>6135 Twillight Court</u> | | 10f. Zip Code <u>21206</u> | | 10g. Citizen of What Country? <u>USA</u> | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>Black</u> | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 th</u> College (1-4 or 5+) <u></u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Mechanic</u> | | 16b. Kind of Business/Industry <u>Automotive</u> | | 17. Father's Name (First, Middle, Last) <u>Howard L. Garnett</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Wilhelmina Greer</u> | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Jeffrey V. Garnett (Brother)</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6135 Twillight Court Balto., Md. 21206</u> | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Voshells Mem. Gardens</u> | | 20c. Location - City or Town, State <u>8/24/99 Dundalk Maryland</u> | |
| 21. Signature of Funeral Service Licensee <u>Dennis B. Caple</u> | | 22. Name and Address of Facility <u>Caple Funeral Service</u> <u>5502 Winner Ave. Balto., Md. 21215</u> | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>CIRRHOSIS OF LIVER</u> Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CARCINOMA OF KIDNEY (PER HISTORY)</u> | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) <u></u> | | 28b. Time of Injury <u>M</u> | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <u>[Signature]</u> | | 29c. License number <u>O.C.M.E.</u> | | 29d. Date signed (Month, Day, Year) <u>August 18, 1999</u> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Margarita Korell M.D.</u> | | 31. Date filed (Month, Day, Year) <u>AUG 24 1999</u> | | 32. Registrar's Signature <u>[Signature]</u> | | 33. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>111 Penn Street, Baltimore, Maryland 21201</u> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26552

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward E. Gardner

2. Date of Death

Month Day Year
August 23, 1999

3. Time of Death

7:20 AM

4a. Facility Name (If not institution, give street and number)

Gilchrist Hospice Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-09-6010

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 12, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4401 Roland Avenue Unit 108

10f. Zip Code

21210

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Proprietor

16b. Kind of Business/Industry

Merchant Sales

17. Father's Name (First, Middle, Last)

Irving Gardner

18. Mother's Name (First, Middle, Maiden Surname)

Carmen Taylor

19a. Informant's Name/Relationship (Type, Print)

Annie R. Gardner (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4401 Roland Avenue Unit 108 Baltimore, Maryland 21210

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial

Date

8/25/99

20c. Location - City or Town, State

Cockeysville, Maryland

21. Signature of Funeral Service Licensee

Lynn B. Henas

22. Name and Address of Facility

Burgee-Henss-Seitz, Inc. 21211
3631 Falls Road, Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SMALL CELL CARCINOMA OF THE LUNG

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Daly MD

29c. License number

D30433

29d. Date signed (Month, Day, Year)

8/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. DALY 6701 N CHARLES ST GBMC BALTIMORE MD 21204

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

B. Sparks

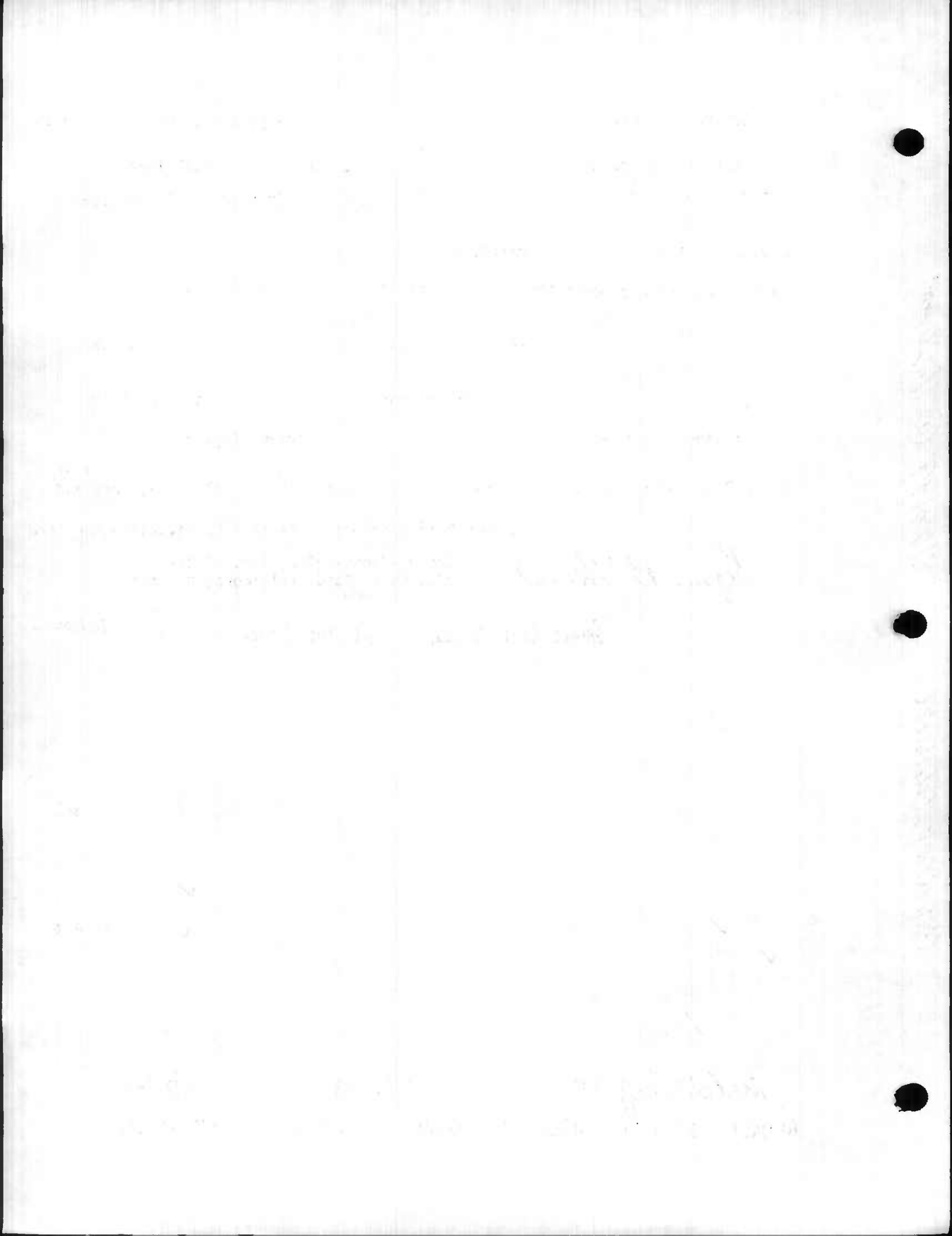
State
Registrar8/23/99 @ 7:20 AM
Baltimore, Maryland 21215-0020Gardner, Edward
Division of Vital Records, P.O. Box 68760,

AH25

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26553

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NALUNGO KOUNBA SASAHOROSAW - HARPER

2. Date of Death

Aug 19 1999

3. Time of Death

2:00PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GILCREST Nursing Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

BALTIMORE

5. Social Security Number

168 46 8307

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 11, 1954

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State
Maryland

10b. County

BALTIMORE

10c. City, Town or Location

WOODLAWN

10d. Inside City Limits

2 ☒ Yes 2 ☐ No

10e. Street and Number

11 SUMMERFIELD ROAD

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SUPERVISOR - DIRECT CARE WORKER

16b. Kind of Business/Industry

CHILDREN'S HOME

17. Father's Name (First, Middle, Last)

Woodrow Watson

18. Mother's Name (First, Middle, Maiden Surname)

JOANNA SPARROW

19a. Informant's Name/Relationship (Type, Print)

KERRY E. HARPER / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2410 WINTER BROOK DR WALKERSVILLE, MARYLAND 21793

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEMETERY

Date

8/25/99

20c. Location - City or Town, State

WOODLAWN, Maryland

21. Signature of Funeral Service Licensee

Gray Harris

22. Name and Address of Facility

CHAIRMAN - HARPER FL
5340 REISTERSTOWN ROAD
BALTIMORE, MD 21215

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

HOTEL

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael...

29c. License number

D30433

29d. Date signed (Month, Day, Year)

8/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR GRAY 6701 N CHARLES ST BALTIMORE MD 21204

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

August 19, 1999 @ 4pm

Nalungo Kounba Harper

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26554

| | | | | | | | | | | |
|---|---|--|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marie E. Hallion | | | | 2. Date of Death Month Day Year August 18, 1999 | | | | 3. Time of Death 9:31 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) Doctors Community Hospital | | | | 4b. City, Town, or Location of Death Lanham | | | | 4c. County of Death Prince George | |
| Funeral Director | 5. Social Security Number 212-66-9071 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 1, 1910 | | 9. Birthplace (State or Foreign Country) Massachusetts | |
| | Usual Residence of Decedent | | | | 10a. State MD | | 10b. County Prince George | | 10c. City, Town or Location Laurel | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number 410 Greenhill Avenue | | | | 10f. Zip Code 20707 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant | | | | 16b. Kind of Business/Industry Federal Government | | | | 17. Father's Name (First, Middle, Last) William B. Flynn | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname) Margaret J. Ahern | | | | 19a. Informant's Name/Relationship (Type, Print) Richard Hallion/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6001 Dewey Drive, Alexandria, Virginia 22310 | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Church Cem. | | | | 20c. Location - City or Town, State Laurel, Maryland | |
| | 21. Signature of Funeral Service Licensee <i>James H. Hark</i> | | | | 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Pneumonia</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| State Registrar | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer's disease</i> <i>congestive heart failure</i> | | | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury M | |
| | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>M. J. Hark MD</i> | |
| To Be Completed by Physician/Medical Examiner | 29c. License number D24283 | | | | 29d. Date signed (Month, Day, Year) 8-19-99 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>M. J. Hark 13631 Baltimore Ave Laurel, MD 20707</i> | |
| | 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Amended Item#8 per FH 6774 8/26/99

99 26555

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph G. Hannon

2. Date of Death
Month Day Year

AUGUST 21 1999

3. Time of Death

10:45 PM

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

215-46-9133

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

10 - 29 - 48

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8618 Saxon Circle

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3 years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Statistician

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Joseph F. Hannon

18. Mother's Name (First, Middle, Maiden Surname)

Emily Breinich

19a. Informant's Name/Relationship (Type, Print)

Barbara A. Hannon (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8618 Saxon Circle, Baltimore, MD 21236

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Grdns.

Date

Aug 25, 1999

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

Mark T. [Signature]

22. Name and Address of Facility

Schimunek Funeral Home, Inc.

9705 Belair Road, Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. ESOPHAGEAL CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

3 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

196592

29d. Date signed (Month, Day, Year)

8/21/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Huzefa Bahrain, MD 9000 FRANKLIN SQUARE DRIVE, BALTIMORE MARYLAND 21237

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

[Signature]

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26556

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|---|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Mary Claire Higgs | | | | 2. Date of Death Month Day Year August 22 1999 | | 3. Time of Death 0458 | |
| 4a. Facility Name (If not institution, give street and number) Fallston General Hospital | | | | 4b. City, Town, or Location of Death Fallston | | 4c. County of Death Harford | |
| 5. Social Security Number 200-30-3389 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 59 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) MAY 12, 1940 | |
| 9. Birthplace (State or Foreign Country) Pennsylvania | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10e. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Bel Air | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 326 Royal Oak Drive | | | | 10f. Zip Code 21015 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Work | | 16b. Kind of Business/Industry Law Firm | |
| 17. Father's Name (First, Middle, Last) Unk. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Unk. | | | |
| 19e. Informant's Name/Relationship (Type, Print) Richard Joseph Higgs/husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 326 Royal Oak Drive Bel Air, MD 21015 | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | Date 8/23/99 | | 20c. Location - City or Town, State Baltimore, MD | |
| 21. Signature of Funeral Service Licensee Dawn F. McDonald | | | | 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. BREAST CANCER Due to (or as a consequence of): b. LUNG METASTASIS Due to (or as a consequence of): c. BRAIN METASTASIS Due to (or as a consequence of): d. RESPIRATORY FAILURE | | | | | | | |
| Approximate Interval Between Onset and Death 5 MONTHS 5 MONTHS 4 MONTHS 1 WEEK | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LEFT BRONCHUS OBSTRUCTION | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how Injury occurred | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier D. Sharma MD | | | | 29c. License number D 31856 | | 29d. Date signed (Month, Day, Year) 08/22/1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D SHARMA, MD 1814 BEL AIR RD MD 21047 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature B. Sparks | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Higgs, Mary Claire

AAH7

jhm
 DWAYNE E
 HAYES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend: Items; #23 Part I, 27 Certificate of Death

Reg. No.

99 26557

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-2222.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
DirectorPhysician
/Medical
Examiner

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Dwayne E. Hayes | | | | 2. Date of Death Month AUGUST Day 21 Year 1999 | | | | 3. Time of Death 00:53 AM | |
| 4a. Facility Name (If not institution, give street and number) JOHN HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death NA | |
| 5. Social Security Number 213-98-3435 | | 6. Sex 15 M 20 F | | 7. Age (In yrs. last birthday) 17 Yrs. | | If Under 1 Year Months Days | | 8. Date of Birth (Month, Day, Year) 09-29-81 | |
| 9. Birthplace (State or Foreign Country) MD | | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 809 N. Patterson Park Avenue | | | | 10f. Zip Code 21205 | | | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1X Never Married 20 Married 30 Widowed 40 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 10 Yes 20 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 Yes 2X No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student | | | | 16b. Kind of Business/Industry Student | |
| 17. Father's Name (First, Middle, Last) Dwayne Hayes | | | | 18. Mother's Name (First, Middle, Maiden Surname) Barbara King | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Sallie King | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205 809 N. Patterson Park Avenue Baltimore, MD | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens | | | | 20c. Location - City or Town, State 08-27-99 Dundalk, MD | |
| 21. Signature of Funeral Service Licenses  | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. GUNSHOT WOUND OF MOUTH | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) | | | | Due to (or as a consequence of): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Due to (or as a consequence of): | | | | | |
| | | | | Due to (or as a consequence of): | | | | | |
| | | | | Due to (or as a consequence of): | | | | | |
| | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 10 Yes 2X No 30 Probably 40 Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? 1X Yes 20 No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1X Yes 20 No | |
| 25. Was case referred to medical examiner? 1X Yes 20 No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 10 Natural 20 Accident 30 Suicide 40 Homicide 51 Pending investigation 60 Could not be determined | | 28a. Date of Injury (Month, Day, Year) 8-21-99 | | 28b. Time of Injury 12:43 M | | 28c. Injury at Work? 10 Yes 2X No | | 28d. Describe how injury occurred SUBJECT WAS SHOT | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 809 N. PATTERSON PK. AVE. BALTIMORE, MD | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  | | | | 29c. License number OCME | |
| | | | | 29d. Date signed (Month, Day, Year) AUGUST 21, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature  | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26558

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Patricia Kathleen Heath

2. Date of Death

Month Day Year
August 23, 1999

3. Time of Death

6:45 am

4a. Facility Name (If not institution, give street and number)

463 Walnut Drive

4b. City, Town, or Location of Death

Edgewater

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

213-80-1649

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

40

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 2, 1959

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Edgewater

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

463 Walnut Drive

10f. Zip Code

21037

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Legal Secretary

16b. Kind of Business/Industry

Law

17. Father's Name (First, Middle, Last)

William Lewis Welsh, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Joan Rexrode

19a. Informant's Name/Relationship (Type, Print)

Joan R. Welsh (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

463 Walnut Drive, Edgewater, MD 21037

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

08/24

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Theresa P. Kutta

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic melanoma (ocular)

Due to (or as a consequence of):

b. nontreatment

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Lorraine M. Dailey M.D.

29c. License number

D21613

29d. Date signed (Month, Day, Year)

8/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lorraine M. Dailey, MD, Edwin Raynor Blvd, Pasadena, MD 21122

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

Lorraine M. Dailey

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

7

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26559

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---|---|--|---|--|--|---|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Joseph H. Hardesty | | | | 2. Date of Death Month Day Year August 21, 1999 | | 3. Time of Death 2:35am | | | |
| | 4a. Facility Name (If not institution, give street and number) Asbury Health Care Center | | | | 4b. City, Town, or Location of Death Solomons | | 4c. County of Death Calvert | | | |
| Funeral Director | 5. Social Security Number 217-38-5882 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) June 3, 1916 | | | |
| | | | | | | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Harwood | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 12 Swallow Lane | | | | 10f. Zip Code 20776 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Collega (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer | | | 16b. Kind of Business/Industry Farming | | | |
| 17. Father's Name (First, Middle, Last) Robert Hardesty | | | | 18. Mother's Name (First, Middle, Maiden Surname) Daisy Burgess | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) David Moreland- Nephew | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Frank Moreland Place, Lothian, MD 20711 | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Calvary Cemetery | | Date 8/24/99 | | 20c. Location - City or Town, State Lothian, MD | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 | | | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. END STAGE AORTIC STENOSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death YR 1 | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D26358 | | 29d. Date signed (Month, Day, Year) AUG. 23, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOHN WEIDER, MD - PRINCEFREDRICK, MD 20678 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

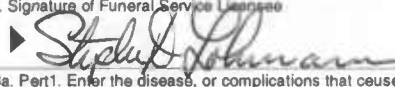
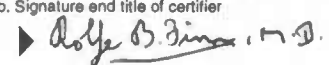
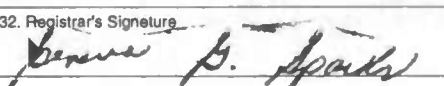
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26560

| | | | | | | | | | |
|---|--|--|--|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Everette HARRISON | | | | 2. Date of Death Month Day Year August 19, 1999 | | 3. Time of Death 2:35 PM | | |
| | 4a. Facility Name (If not institution, give street and number) Joseph Richey House Hospice | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death n/a | | |
| Funeral Director | 5. Social Security Number 215 42 5643 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 55 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 18, 1943 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County n/a | | 10c. City, Town or Location Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 930 Chauncey Ave. | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 1 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Artist | | 16b. Kind of Business/Industry Self Employed | | | | | |
| 17. Father's Name (First, Middle, Last) Everett B. Harrison | | | | 18. Mother's Name (First, Middle, Maiden Surname) Alethea Peters | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Bettye Harrison-Burns / Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt.1 Box 446R, Kearneysville, WV 25430 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory | | Date 8/21/99 | | 20c. Location - City or Town, State Baltimore, MD | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>a. Respiratory arrest Due to (or as a consequence of):</p> <p>b. Widespread pulmonary & cerebral metastases Due to (or as a consequence of):</p> <p>c. Non-small cell adenocarcinoma of @ upper lung lobe Due to (or as a consequence of):</p> <p>d.</p> </div> </div> | | | | | | | | Approximate Interval Between Onset and Death Minutes 6 months 7 years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. (c) mastoiditis | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number 902175 | | 29d. Date signed (Month, Day, Year) 8-19-99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rolfe B. FENN 8824 Winards Road, Randallstown, MD 21133 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature  | | | | | | | |

To Be Completed by Funeral Director

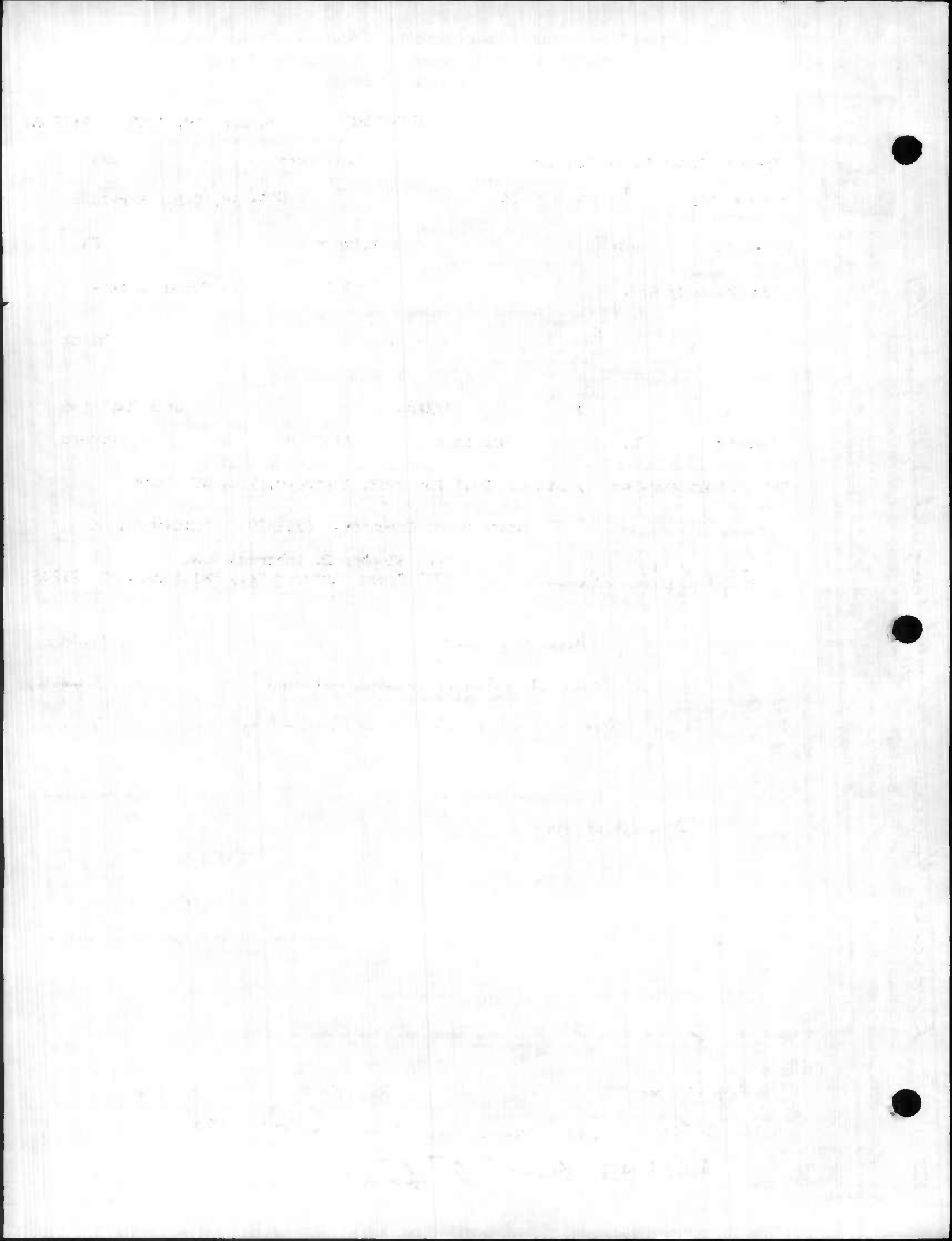
Medical Certification: To Be Completed by Physician/Medical Examiner

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMEND #1 PER MD. G775 9-18-99 J.A.

99 26561

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>ELIJAH ANTHONY JOHNSON SR.</u> | | | | 2. Date of Death Month Day Year <u>AUGUST 21 1999</u> | | 3. Time of Death <u>0625</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>UNIVERSITY OF MARYLAND HOSPITAL</u> | | | | 4b. City, Town, or Location of Death <u>BALTIMORE</u> | | 4c. County of Death <u>N/A</u> | |
| Funeral Director | 5. Social Security Number <u>220-84-9658</u> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>36</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>NOV. 24, 1962</u> | |
| | 9. Birthplace (State or Foreign Country) <u>Maryland</u> | | 10a. State <u>Maryland</u> | | 10b. County <u>N/A</u> | | 10c. City, Town or Location <u>Baltimore</u> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 11. Street and Number <u>1164 WASHINGTON BLVD</u> | | | |
| | 11f. Zip Code <u>21230</u> | | | | 11g. Citizen of What Country? <u>USA</u> | | | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>black</u> | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 YEARS</u> College (1-4 or 5+) _____ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Janitor</u> | | 16b. Kind of Business/Industry <u>Eastern Standard Manufacturers</u> | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) <u>ELIJAH JOHNSON</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Mary C. Harris</u> | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <u>Arthur Drumwright / father</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4022 Edmondson Ave Baltimore, Md 21229</u> | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Nt. Lion Cemetery</u> | | 20c. Location - City or Town, State <u>Baltimore, Maryland</u> | | 20d. Date <u>8/25/99</u> | |
| | 21. Signature of Funeral Service Licensee <u>[Signature]</u> | | 22. Name and Address of Facility <u>CHAPMAN - HARRIS B.H.</u> <u>540 REISTERSTOWN ROAD</u> <u>Baltimore, Md 21215</u> | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) a. <u>SEPSIS</u> Due to (or as a consequence of): b. <u>END STAGE RENAL DISEASE</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | 2 DAYS |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | 29f. Date signed (Month, Day, Year) <u>AUGUST 21 1999</u> |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier <u>[Signature], MD</u> | | 29c. License number <u>P13358</u> | | 29d. Date signed (Month, Day, Year) <u>AUGUST 21 1999</u> | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>TOMAS H. AYALA - 22 S. GREENE ST. BALTIMORE MD 21201</u> | | | | | | | 31. Date filed (Month, Day, Year) <u>AUG 24 1999</u> |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year) <u>AUG 24 1999</u> | | 32. Registrar's Signature <u>[Signature]</u> | | | | | |
| | 33. Registrar's Name <u>B. Sparks</u> | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26562

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Hazel H Jordan

2. Date of Death

Month
AUGUSTDay
19Year
1999

3. Time of Death

4:45 A.M.

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

218-32-9972

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

December 15, 1919

9. Birthplace (State or Foreign Country)

Baltimore, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes 2 ☒ No X

10e. Street and Number

4401 Ridge Road

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Antique Dealer

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

James F Hampshire

18. Mother's Name (First, Middle, Maiden Surname)

Sadie Boulden

19a. Informant's Name/Relationship (Type, Print)

Dianne Younts

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5718 Arnhem Road Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. August 20, 1999

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Dianne Younts

22. Name and Address of Facility

Lassahn Funeral Home, Inc.

7401 Belair Road Baltimore, Maryland 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ENDSTAGE COPD
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

June Allen MD

29c. License number

D0053758

29d. Date signed (Month, Day, Year)

Aug. 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6569 N. Charles St. #601 Bal H. MD 21204

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

B. Sparks

State
Registrar

ADH
SHAWN JACKSON
99-4814-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 8 PER F.H. G774 8-24-99 WR.

Certificate of Death

Reg. No. 99 26563

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

| | | | | | |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) SHAWN JACKSON | | 2. Date of Death Month Day Year AUGUST 17, 1999 | | 3. Time of Death 1935 PM | |
| 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | |
| 5. Social Security Number 213-04-0381 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 16 Yrs. | |
| 8. Data of Birth (Month, Day, Year) 5/30/99 | | 9. Birthplace (State or Foreign Country) Md. | | 10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10a. State Md. | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10e. Street and Number 1600 Cliftview Ave. | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. BLACK | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NEVER WORK | |
| 16b. Kind of Business/Industry none | | 17. Father's Name (First, Middle, Last) Melvin Jackson | | 18. Mother's Name (First, Middle, Maiden Surname) Nona Jenkins | |
| 19a. Informant's Name/Relationship (Type, Print) Danyael Jenkins | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 Cliftview Ave. Baltimore, Md. 21213 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. Zion Cemetery | | 20c. Location - City or Town, State Baltimore, Maryland | |
| 20d. Date 8/25/99 | | 21. Signature of Funeral Service Licensee James Cromartie | | | |
| 22. Name and Address of Facility Betts Funeral Home | | 22. Name and Address of Facility 1129 N. Caroline St. Balto., Md. 21213 | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Multiple gunshot wounds Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 8/17/99 | | 28b. Time of Injury 0054 HR | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject shot | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) house steps | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1500 block Cliftview Avenue Baltimore, Maryland | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Theodore M. King | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) AUGUST 18, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature B. Sparks | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26561

Amended Item 4, PER FH G775 9/29/99dnhb

| | | | | | | | | | | | | | |
|--|---|---|---------------------------------|--|---|--|--|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Charles Johnson JR</u> | | | | 2. Date of Death Month <u>Aug</u> Day <u>18</u> Year <u>1999</u> | | 3. Time of Death <u>1512</u> | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) <u>Bayview Medical Center</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>N/A</u> | | | | | | |
| Funeral Director | 5. Social Security Number <u>213-96-0352</u> <u>213-60-5551</u> | | 6. Sex <u>1</u> M <u>2</u> F | 7. Age (In yrs. last birthday) <u>22</u> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <u>NOV 6 1976</u> | 9. Birthplace (State or Foreign Country) <u>MARYLAND</u> | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| 10a. State <u>MARYLAND</u> | | 10b. County <u>N/A</u> | | 10c. City, Town or Location <u>BALTIMORE CITY</u> | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 10e. Street and Number <u>4315 KATHLAND AVENUE</u> | | | | 10f. Zip Code <u>21207</u> | | 10g. Citizen of What Country? <u>U.S.A.</u> | | | | | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u> | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 yrs</u> College (1-4 or 5+) <u>1 yr</u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>FRONT DESK MANAGER</u> | | | 16b. Kind of Business/Industry <u>HOTEL</u> | | | | | | |
| 17. Father's Name (First, Middle, Last) <u>CHARLES JOHNSON SR.</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>CHERYL E DAWES</u> | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>CHARLES JOHNSON SR/Father</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4315 Kathland Avenue, Baltimore, Maryland 21207</u> | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>KING MEMORIAL PARK</u> | | Date <u>8-23-99</u> | | 20c. Location - City or Town, State <u>BALTIMORE, MARYLAND</u> | | | | | | | |
| 21. Signature of Funeral Service Licensee <u>Barbara H. Brown</u> | | | | 22. Name and Address of Facility <u>WILLIAM C BROWN COMMUNITY FUNERAL HOME PA</u> <u>1206 W NORTH AVENUE</u> | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. <u>Sepsis</u> Due to (or as a consequence of):</td> </tr> <tr> <td>b. <u>75% Total Body Surface Area Burns</u> Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>Sepsis</u> Due to (or as a consequence of): | b. <u>75% Total Body Surface Area Burns</u> Due to (or as a consequence of): | c. _____ Due to (or as a consequence of): | d. _____ Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>Sepsis</u> Due to (or as a consequence of): | | | | | | | | | | | | |
| | b. <u>75% Total Body Surface Area Burns</u> Due to (or as a consequence of): | | | | | | | | | | | | |
| | c. _____ Due to (or as a consequence of): | | | | | | | | | | | | |
| | d. _____ Due to (or as a consequence of): | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Patient in multiorgan failure - liver, kidney, lungs due to bacteremia and fungemia</u> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) <u>June 20 1999</u> | | 28b. Time of Injury <u>unk</u> M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred <u>subject found gasoline on self + ignited flame</u> | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u>Basement of home</u> | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <u>KATHLAND AVE, 4315</u> | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <u>Mark Coffey</u> | | | | 29c. License number <u>RS-000</u> | | 29d. Date signed (Month, Day, Year) <u>Aug 18 1999</u> | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Mark Coffey 1900 Thames St. #407 Baltimore MD 21231</u> | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>AUG 24 1999</u> | | | | 32. Registrar's Signature <u>B. Sparks</u> | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

946

DHMH 16 Rev 6/95

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #10e PER FH G775 9/2/99 AH

Certificate of Death

Reg. No. 99 26565

| | | | | | | | | | | |
|---|--|--|---|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Paul Michael Kenney, Sr. | | | | 2. Date of Death Month Day Year August 19, 1999 | | 3. Time of Death 4:25 AM | | | |
| | 4a. Facility Name (If not institution, give street and number) St. Joseph Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | | | |
| Funeral Director | 5. Social Security Number 217-36-4813 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 59 Yrs. | | 8. Date of Birth (Month, Day, Year) 11-13-1939 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Timonium | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 2214 WESTRIDGE ROAD 2214 Westridge Road | | | | 10f. Zip Code 21093 | | 10g. Citizen of What Country? U. S. A. | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Property Manager | | | 16b. Kind of Business/Industry Town & Country Management | | | |
| 17. Father's Name (First, Middle, Last) Hiram Kenney | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Alt | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs Gale M. Kenney (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2214 Westridge Road, Timonium, Maryland | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gards. | | | Date 8-23-99 | | 20c. Location - City or Town, State Timonium, Maryland | | |
| 21. Signature of Funeral Service Licensee Wallace S. Brooks, Jr. | | | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland, 1050 York Road | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. myocardial infarction Due to (or as a consequence of): ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Diabetes mellitus Due to (or as a consequence of): c. d. | | | | | | | Approximate Interval Between Onset and Death 5 min 3 yrs 5 yrs | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier George T. Gilmore | | | | 29c. License number D02325 | | 29d. Date signed (Month, Day, Year) 8/20/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE T. GILMORE 13221-3 Tullamore Rd, Timonium, Md | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature James B. Sparks | | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26566

| | | | | | | | | |
|--|---|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Carroll Edwin Lloyd, Sr. | | | | 2. Date of Death Month Day Year August 22 1999 | | 3. Time of Death 2133 | |
| | 4a. Facility Name (If not institution, give street and number) St. Agnes Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 216.34.4818 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 61 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 17, 1938 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2815 Sunset Drive | | 10f. Zip Code 21223 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1955-1959 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Officer | | 16b. Kind of Business/Industry Law Enforcement | | | | |
| 17. Father's Name (First, Middle, Last) Charles T. Lloyd | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Grap | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Gladys R. Lloyd/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2815 Sunset Dr. Baltimore, Md. 21223 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | 20c. Date 8/26 | | 20d. Location - City or Town, State Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Sterling-Ashton-Schwab 736 Edmondson Ave. Catonsville, Md. 21228 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. SEVERE DIFFUSE CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 hour 5 years | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease hypertension non insulin dependent diabetes mellitus | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DUA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number D 22648 | | 29d. Date signed (Month, Day, Year) August 22, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jerome I. Snyder, M.D. 900 SOUTH CATON AVENUE BALTIMORE, MARYLAND 21229 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

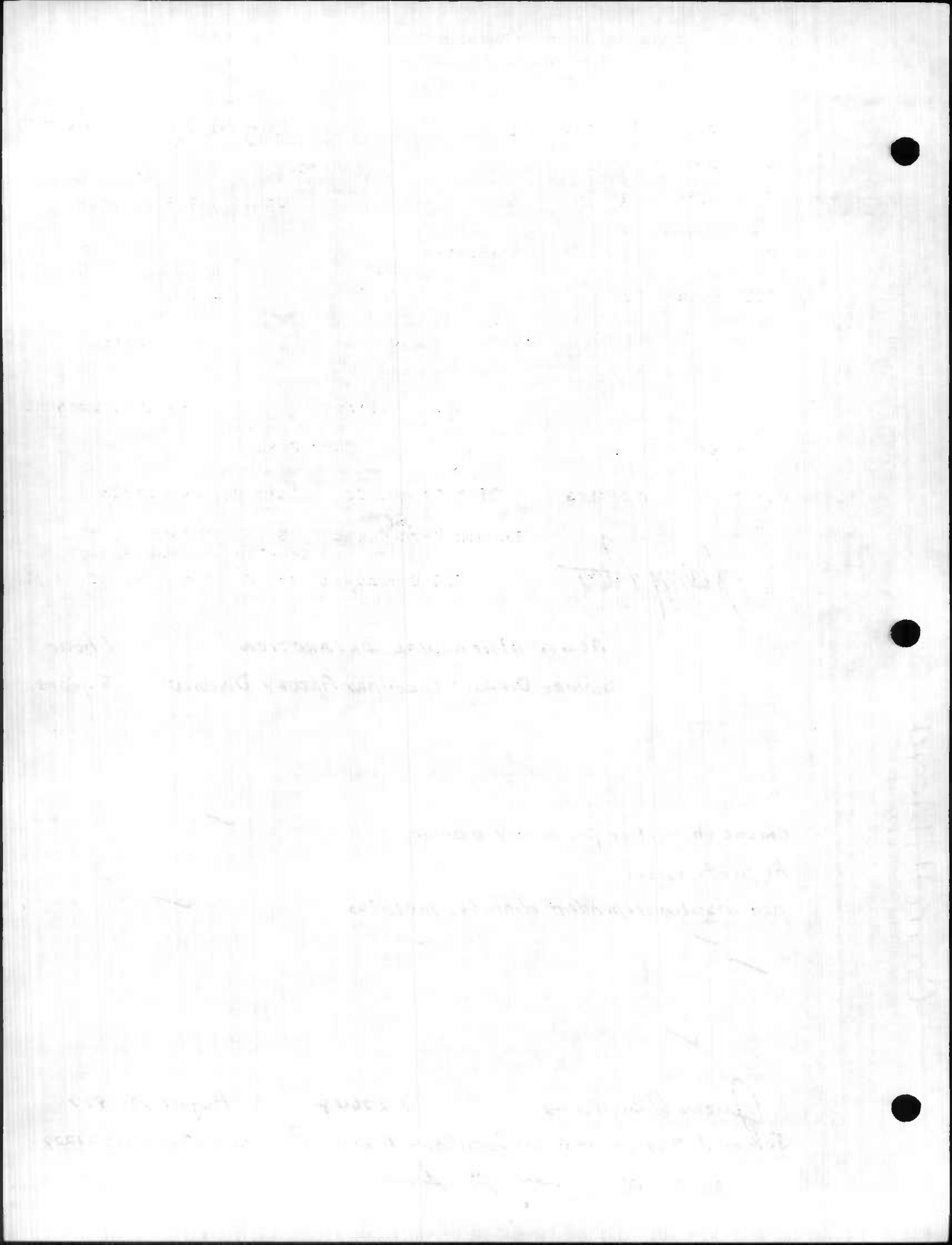
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Carroll, Lloyd
Division of Vital Records, P.O. Box 68760,

15

State
Registrar



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26567

Physician
/Medical
Examiner

1. Decedant's Name (First, Middle, Last)

LAWRENCE LEIGHT

2. Date of Death

Month
AugustDay
20Year
1999

3. Time of Death

10:40 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Keswick Multicare Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

215-01-5718

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

MAY 06, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Parkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1929 Bulls Sawmill Road

10f. Zip Code

21053

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Baltimore Gas & Electric

17. Father's Name (First, Middle, Last)

Unk.

18. Mother's Name (First, Middle, Maiden Surname)

Unk.

19a. Informant's Name/Relationship (Type, Print)

Robert McAllister/Per. Rep. 1339 Blue Mount Rd. Monkton, MD 21111

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc. 08/23/99

Data

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. PROGRESSIVE PARKINSON'S DISEASE

Due to (or as a consequence of):

b. DEMENTIA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

6 YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aspiration Pneumonia (Recurrent)

Seizure Disorder

Urinary Tract Infection

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles J. Donovan M.D.

29c. License number

J12399

29d. Date signed (Month, Day, Year)

August 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles J. Donovan M.D. Keswick 700 W. 40th St. Baltimore, MD 21211

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

B. Sparks

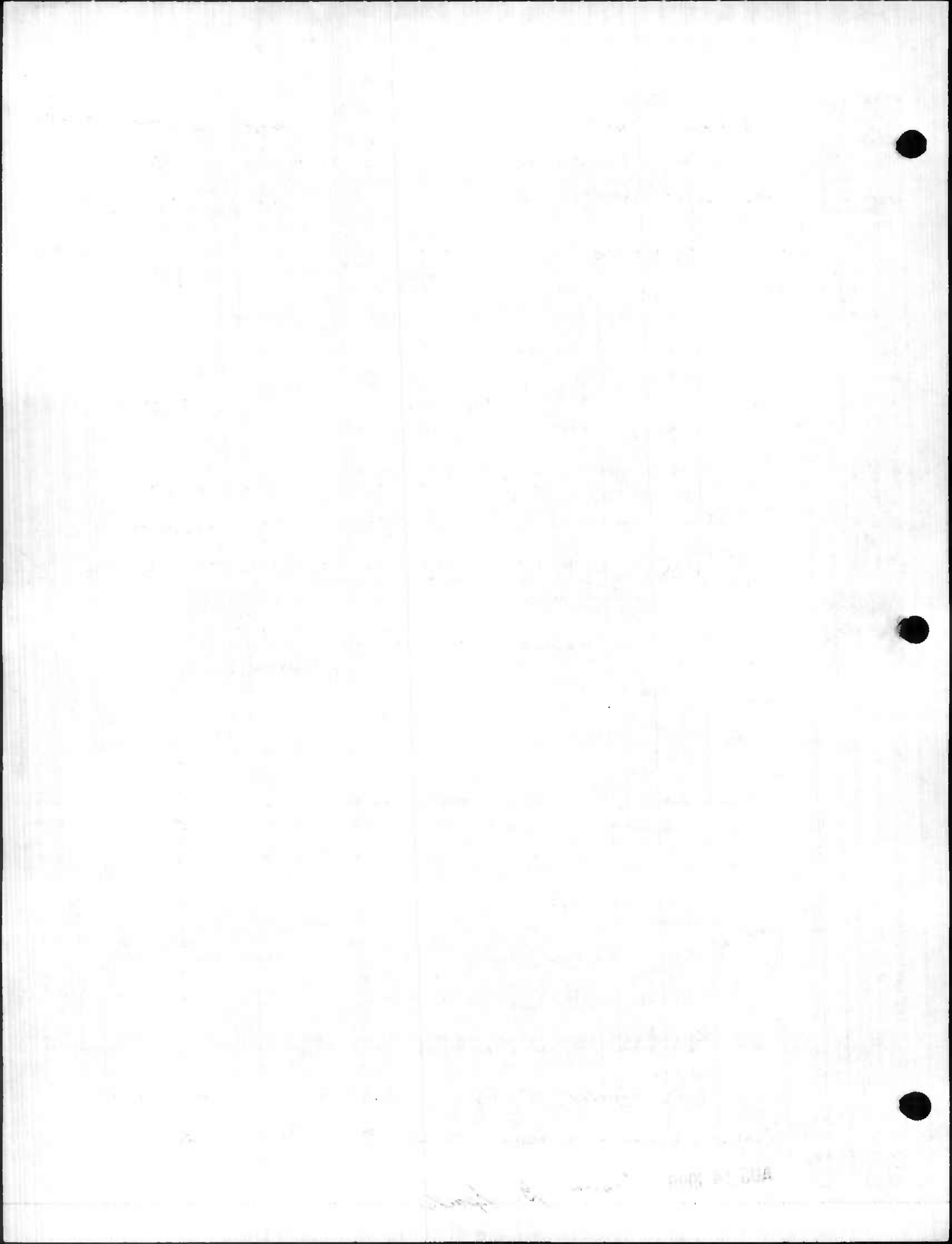
State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26568

| | | | | | | | | |
|---|---|--|--|--|---|--------------------------------|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>James A. Lipscomb Jr.</i> | | | | 2. Date of Death Month <i>August</i> Day <i>19</i> Year <i>1999</i> | | 3. Time of Death <i>6:35 pm</i> | |
| | 4a. Facility Name (If not Institution, give street and number) <i>Union Memorial Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>N/A</i> | |
| Funeral Director | 5. Social Security Number <i>212-28-7245</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>80</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>Nov. 18, 1918</i> | 9. Birthplace (State or Foreign Country) <i>Maryland</i> |
| | Usual Residence of Decedent | | | | 10a. State <i>Maryland</i> | | 10b. County <i>N/A</i> | |
| To Be Completed by Funeral Director | 10c. City, Town or Location <i>Baltimore</i> | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number <i>1100 Bolton Street</i> | |
| | 10f. Zip Code <i>21201</i> | | | | 10g. Citizen of What Country? <i>USA</i> | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | |
| | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>N/A</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Supervisor</i> | | 16b. Kind of Business/Industry <i>Janitorial</i> | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) <i>James Lipscomb</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Birdie Lipscomb</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <i>Stacey Shaw-Daughter</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>700 W. North Ave, Baltimore MD 21217</i> | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Zion</i> | | 20c. Location - City or Town, State <i>Baltimore, MD.</i> | |
| | 21. Signature of Funeral Service Licensee <i>Carlton P. Douglass</i> | | | | 22. Name and Address of Facility <i>Douglass Funeral Service 1701 McCulloh Street, Baltimore, MD. 21217</i> | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Sepsis</i> Due to (or as a consequence of): <i>Bilateral Pneumonia</i> Due to (or as a consequence of): <i>Severe COPD</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death <i>24 hrs</i> <i>20 days</i> <i>15 years</i> | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>malnutrition</i> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| | 29b. Signature and title of certifier <i>Carlton P. Douglass</i> | | | | 29c. License number <i>AT 2438946 C12</i> | | 29d. Date signed (Month, Day, Year) <i>August 19 1999</i> | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Ricardo De Jesus Union Memorial Hospital</i> | | | | | | | |
| | 31. Date filed (Month, Day, Year) <i>AUG 24 1999</i> | | | | 32. Registrar's Signature <i>Brenda B. Sparks</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26569

| | | | | | | | | |
|---|--|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LORRINE ELIZABETH WENTZ McLELLAN | | | | 2. Date of Death Month Day Year AUGUST 21 1999 | | 3. Time of Death 10:50 AM | |
| | 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 217-64-2714 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 82 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec 6, 1916 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | 10a. State Maryland | | 10b. County Baltimore County | | 10c. City, Town or Location Idlewyld | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 6210 Beechwood Road | | 10f. Zip Code 21239 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Proprietor | | 16b. Kind of Business/Industry Delicatessen | | | | |
| 17. Father's Name (First, Middle, Last) John Walter Wentz | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lillian Eva Wilhelmina Thomas | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Walter J. McLellan (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6210 Beechwood Road, Baltimore, MD 21239 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Grdns | | 20c. Date 8/25/99 | | 20d. Location - City or Town, State Timonium, Maryland | | |
| 21. Signature of Funeral Service Licensee  Martin D. Lawson | | | | 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212 | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METASTATIC ADENO CARCINOMA OF LUNG | | | | | | | | Approximate Interval Between Onset and Death 2 MONTHS |
| Immediate Cause (Final disease or condition resulting in death) METASTATIC ADENO CARCINOMA OF LUNG | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D 37254 | | 29d. Date signed (Month, Day, Year) 8/21/99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BOON P. LIM M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AH12

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

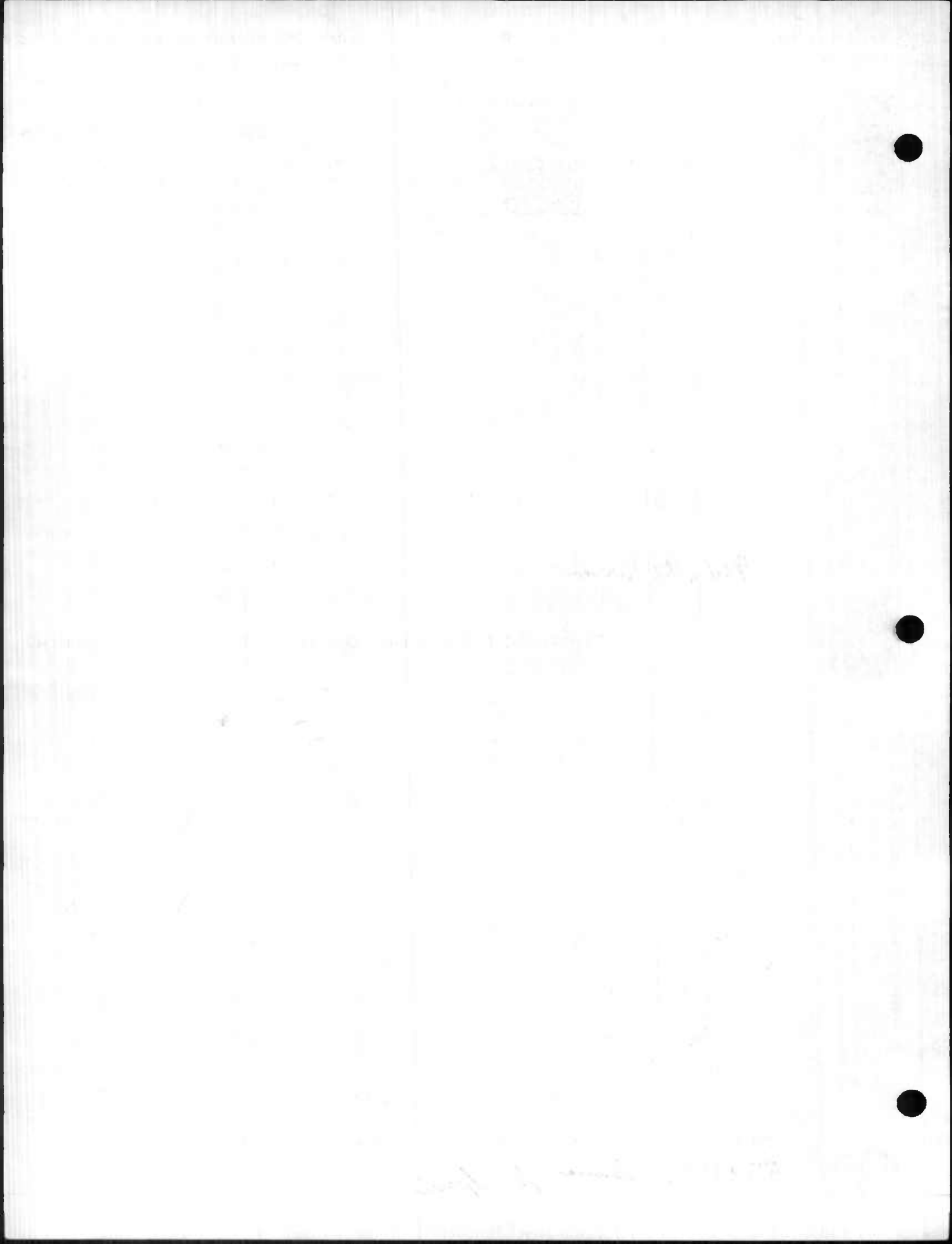
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26570

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MARY GERTRUDE MUTH

2. Date of Death
Month Day Year

August 23 1999

3. Time of Death

9:45 am

4a. Facility Name (If not Institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

220-30-0008

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 2, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2300 Dulaney Valley Road

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Church

17. Father's Name (First, Middle, Last)

Edward Sebastian Muth

18. Mother's Name (First, Middle, Maiden Surname)

Anna Gertrude Arning

19a. Informant's Name/Relationship (Type, Print)

Joseph L Muth Jr Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5401 Loch Raven Blvd. Baltimore, Maryland 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral

Date

8/25/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Dennis Stephen Kenakis

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home Inc.
6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. DEMENTIA

Due to (or as a consequence of):

b. ANEMIA

Due to (or as a consequence of):

c. DIABETES

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dennis Stephen Kenakis MD

29c. License number

15504

29d. Date signed (Month, Day, Year)

8-23-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eddie Makhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21293

State
Registrar

31. Date filed (Month, Day, Year)

AUG 24 1999

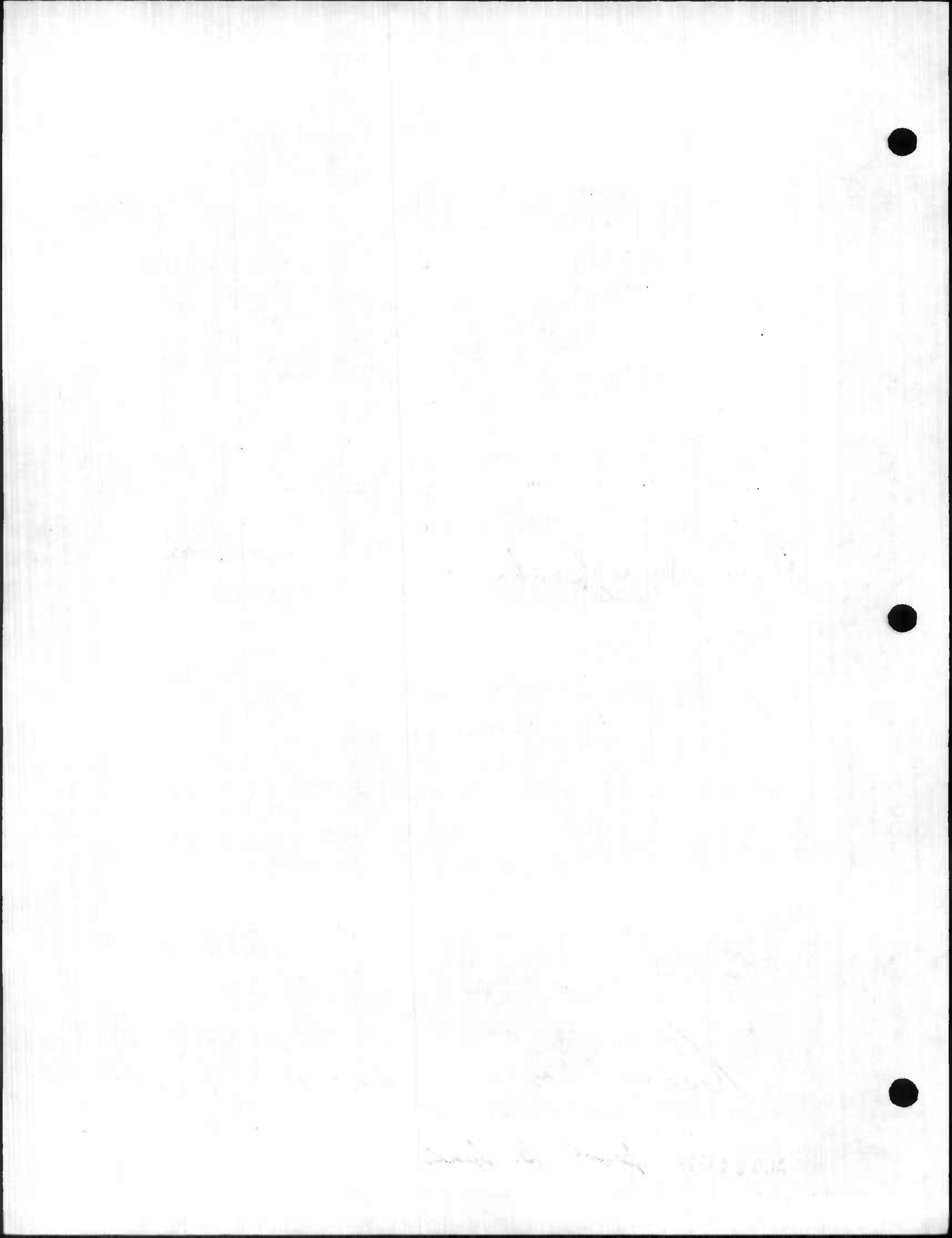
32. Registrar's Signature

*B. Sparks*Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME: MARY GERTRUDE MUTH
Division of Vital Records, P.O. Box 68760,To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26571

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|--|--|---|--|--|---|---|--|----------------------------------|--|---------------------------------------|-----------------|----------------------------------|--|--|--|----------------|----------------------------------|--|----|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CLARENCE PAUL MOSES | | | | 2. Date of Death Month Day Year August 20 1999 | | 3. Time of Death 9:23 | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not Institution, give street and number) The Johns Hopkins Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 220-84-1005 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 30 Yrs. | | 8. Date of Birth (Month, Day, Year) 08-30-68 | | | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location N/A | | | | | | | | | | | | | | | | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 1720 SEVERN TREE COURT | | 10f. Zip Code 21144 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH GRADE College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECURITY GUARD | | 16b. Kind of Business/Industry EES | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) CLARENCE MOSES | | | | 18. Mother's Name (First, Middle, Maiden Surname) PAULA MAELIN | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) PAMELA MOSES WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1720 SEVERN TREE CT, RANDALLSTOWN MD 21144 | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOW RIDGE CEMETERY | | 20c. Location - City or Town, State 8-26-99 ELKRIE, MD | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee Vaughn C. Greene | | | | 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALD. NAT'L PIKE, BALD. MD. 21229 | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. ADULT RESPIRATORY DISTRESS SYNDROME</td> <td>Approximate Interval Between Onset and Death 6 WEEKS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. ORTHOtopic LIVER TRANSPLANT</td> <td>8 MONTHS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. PRIMARY SCLEROSING CHOLANGITIS</td> <td>6 YEARS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">d.</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. ADULT RESPIRATORY DISTRESS SYNDROME | Approximate Interval Between Onset and Death 6 WEEKS | Due to (or as a consequence of): | | b. ORTHOtopic LIVER TRANSPLANT | 8 MONTHS | Due to (or as a consequence of): | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. PRIMARY SCLEROSING CHOLANGITIS | 6 YEARS | Due to (or as a consequence of): | | d. | |
| Immediate Cause (Final disease or condition resulting in death) | a. ADULT RESPIRATORY DISTRESS SYNDROME | Approximate Interval Between Onset and Death 6 WEEKS | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | |
| | b. ORTHOtopic LIVER TRANSPLANT | 8 MONTHS | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. PRIMARY SCLEROSING CHOLANGITIS | 6 YEARS | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Frances R. Jensen, MD | | | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) August 20, 1999 | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCES R. JENSEN, MD JOHNS HOPKINS HOSPITAL BALTIMORE, MARYLAND | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature D. Sparks | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Subject: [illegible]
[illegible]
[illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26572

| | | | | | | | | |
|--|---|--|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Thomas M. Mohler | | | | 2. Date of Death Month August Day 21 Year 1999 | | 3. Time of Death 6:45 PM | |
| | 4a. Facility Name (If not institution, give street and number) Baltimore Veterans Administration Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death n/a | |
| Funeral Director | 5. Social Security Number 226-182567 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) April 21, 1921 | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State Maryland | | 10b. County Howard | | 10c. City, Town or Location Elkridge | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 5972 Elk Forest Court | | 10f. Zip Code 21075 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1948-50 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contractor | | 16b. Kind of Business/Industry Home Improvement | | 17. Father's Name (First, Middle, Last) John M. Mohler | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Rena Belle Fitzgerald | | 19a. Informant's Name/Relationship (Type, Print) Pamela J. Gavin/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5972 Elk Forest Court Elkridge, MD 21075 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park | | 20c. Date 8/24/99 | | 20d. Location - City or Town, State Elkridge, Maryland | | 21. Signature of Funeral Service Licensee | | |
| 22. Name and Address of Facility Gary L. Kaufman Fun. Home @ Meadowridge Mem. Park 7250 Washington Blvd. Elkridge, MD 21075 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Pulmonary Fibrosis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | |
| 29c. License number P12392 | | 29d. Date signed (Month, Day, Year) AUGUST 21, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IFE FADEN MD 10 GREENE Street, Baltimore MD | | 31. Date filed (Month, Day, Year) AUG 24 1999 | | |
| 32. Registrar's Signature | | 33. State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | 35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | | |

Received of _____

the sum of _____

for _____

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

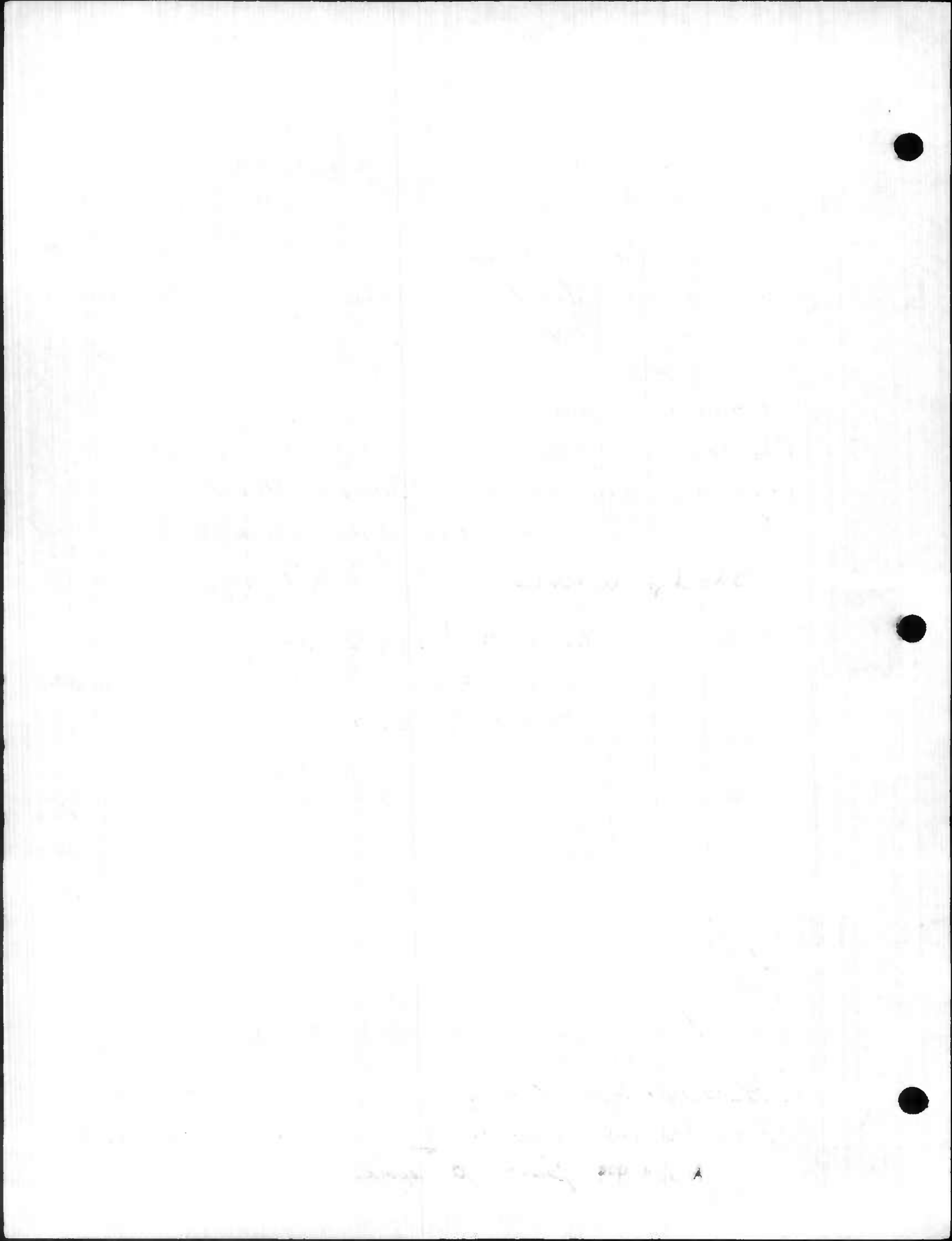
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26573

| | | | | | | | | |
|---|---|-----------------------------|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Claude Mitchell</i> | | | | 2. Date of Death Month <i>August</i> Day <i>19</i> Year <i>1999</i> | | 3. Time of Death <i>6:30 P.M.</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>6426 Gilmore Street</i> | | | | 4b. City, Town, or Location of Death <i>Woodlawn</i> | | 4c. County of Death <i>Balto</i> | |
| Funeral Director | 5. Social Security Number <i>216-50-0048</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>50</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>10-21-1948</i> | 9. Birthplace (State or Foreign Country) <i>MD</i> |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State <i>MD</i> | 10b. County <i>Balto</i> | 10c. City, Town or Location <i>Woodlawn</i> | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number <i>6426 Gilmore Street</i> | | | | 10f. Zip Code <i>21207</i> | | 10g. Citizen of What Country? <i>U.S.A</i> | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i> College (1-4 or 5+) <i>NA</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>longshoreman</i> | | 16b. Kind of Business/Industry <i>Waterfront</i> | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) <i>Claude Lee Mitchell</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Rosa Lee Newborn</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <i>Veronica Mitchell - wife</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6426 Gilmore Street Woodlawn, MD 21207</i> | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>King Memorial Park</i> | | 20c. Location - City or Town, State <i>8/26/99 Randallstown, MD</i> | | 20d. Date <i>21215</i> | |
| | 21. Signature of Funeral Service Licensee <i>Glenn W. Wane</i> | | | | 22. Name and Address of Facility <i>March F. H. West 4300 Wabash Avenue Balto, MD</i> | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) <i>Metastatic Colon Cancer</i> | | | | | | | <i>2 yrs</i> |
| | Due to (or as a consequence of): <i>Severe Anemia</i> | | | | | | | <i>3 months</i> |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Failure to thrive</i> | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | |
| | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier <i>James Elder MD Attending</i> | | 29c. License number <i>D38993</i> | | 29d. Date signed (Month, Day, Year) <i>08/20/99</i> | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>James Elder MD 2600 Liberty Hgts Baltimore MD 21215</i> | | | | | | | |
| | 31. Date filed (Month, Day, Year) <i>AUG 24 1999</i> | | 32. Registrar's Signature <i>James B. Sparks</i> | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26574

| | | | | | | | | |
|--|---|---|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Josephine V. Miglioretti</i> | | | | 2. Date of Death Month <i>AUGUST</i> Day <i>23</i> Year <i>1999</i> | | 3. Time of Death <i>10:10 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>Saint Joseph Medical Center</i> | | | | 4b. City, Town, or Location of Death <i>Towson</i> | | 4c. County of Death <i>Baltimore</i> | |
| Funeral Director | 5. Social Security Number <i>215-03-7289</i> | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>100</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>July 15 1899</i> | |
| | 9. Birthplace (State or Foreign Country) <i>Italy</i> | | 10a. State <i>Md</i> | | 10b. County <i>Baltimore</i> | | 10c. City, Town or Location <i>Parkville</i> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number <i>3021 California Ave.</i> | | 10f. Zip Code <i>21234</i> | | 10g. Citizen of What Country? <i>USA</i> | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>—</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>homemaker</i> | | 16b. Kind of Business/Industry <i>home</i> | | | |
| | 17. Father's Name (First, Middle, Last) <i>Joseph Vicareini</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Erminia Sperafico</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <i>Catherine Croff sister</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3021 California Ave. Baltimore, Md 21234</i> | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Parkwood Cemetery</i> | | 20c. Location - City or Town, State <i>Parkville, Md</i> | | 20d. Date <i>Aug 26 1999</i> | |
| | 21. Signature of Funeral Service Licensee <i>Krista S. Wells</i> | | | | 22. Name and Address of Facility <i>Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234</i> | | | |
| | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>SEPTICEMIC DUE TO CHOLANGITIS</i> a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| | Approximate Interval Between Onset and Death <i>2 WEEKS</i> | | | | | | | |
| | Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Natividad D. de Leon, M.D.</i> | | | | 29c. License number <i>D 19508</i> | | 29d. Date signed (Month, Day, Year) <i>August 23, 1999</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>NATIVIDAD D. DE LEON M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204</i> | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year) <i>AUG 24 1999</i> | | 32. Registrar's Signature <i>B. Sparks.</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26575

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARIAN RENA MYERS

2. Date of Death
Month Day Year
August 18, 1999
3. Time of Death
3:20 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

218-03-1138

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

8. Date of Birth (Month, Day, Year)

DEC 12 1915

9. Birthplace (State or Foreign Country)

RHODE ISLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

WHITE MARSH

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

336 LORLEY ROAD

10f. Zip Code

21162

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
11th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

CEPHAS JOHNSON

18. Mother's Name (First, Middle, Maiden Surname)

RENA JOHNSON

19a. Informant's Name/Relationship (Type, Print)

Thomas Myers/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13364 Warwick Spring Dr. Newport News, VA

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ASBURY CHURCH CEMETERY

Date

8-21-99

20c. Location - City or Town, State

WHITE MARSH, MARYLAND

21. Signature of Funeral Service Licensee

Barbara A. Brown

22. Name and Address of Facility

WILLIAM C BROWN COMMUNITY FUNERAL HOME-ABERDEEN
321 S PHILADELPHIA BLVD ABERDEEN MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Posterior Circulation Infarction
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

[Signature]

29c. License number

RD 196592

29d. Date signed (Month, Day, Year)

August 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr HuzeFa Bahrain 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

[Signature]

State
Registrar

ORIGINAL

Myers, Maryland 21215-0020
Baltimore, Maryland 21215-0020
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26576

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Milton Noble

2. Date of Death

Month Day Year
August 20, 1999

3. Time of Death

7:35 A.M.

4a. Facility Name (If not institution, give street and number)

Blakehurst

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

215-03-0207

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
4-14-1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1055 W. Joppa Road

10f. Zip Code

21204

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Treasurer

16b. Kind of Business/Industry

Noxell

17. Father's Name (First, Middle, Last)

James F. Noble

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Bunting

19a. Informant's Name/Relationship (Type, Print)

Mrs Anna E. Noble (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1055 W. Joppa Road, Towson, Maryland 21204

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parkwood Cemetery

Date

8-23-99

20c. Location - City or Town, State

Parkville, Maryland

21. Signature of Funeral Service Licensee

Wallace S. Brooks, Jr.

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road, Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary arrest

Due to (or as a consequence of):

Approximate interval Between Onset and Death

15 min

b. Stroke

Due to (or as a consequence of):

30 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Atrial Fibrillation

Due to (or as a consequence of):

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William D. McConnell MD

29c. License number

042129

29d. Date signed (Month, Day, Year)

8-20-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William D. McConnell MD 500 W. University Baltimore 21210

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

Kenna B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

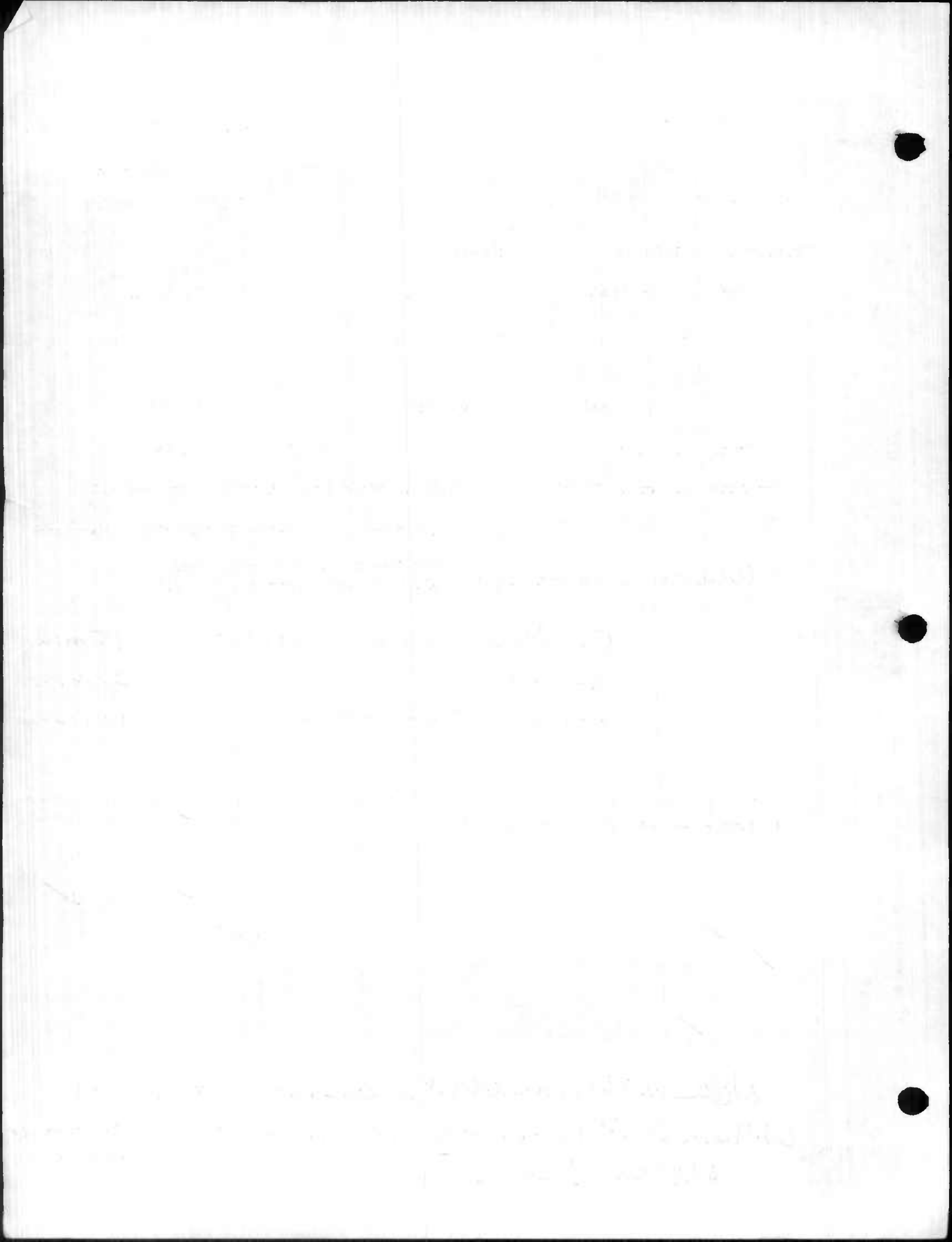
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26577

AMMIE NELSON AUGUST 20, 1999 3:15 a.m.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) AMMIE LEE NELSON | | | | 2. Date of Death Month Aug. Day 20 Year 1999 | | 3. Time of Death 3:15 AM | |
| 4a. Facility Name (If not institution, give street and number) Hella Maris Hospice | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore | |
| 5. Social Security Number 217-26-0321 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 90 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 25, 1909 | |
| 9. Birthplace (State or Foreign Country) Georgia | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Romolston | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 8629 LUCERNE ROAD | | | | 10f. Zip Code 21133 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th grade College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEKEEPER | | 16b. Kind of Business/Industry Private family | |
| 17. Father's Name (First, Middle, Last) MITCHELL SIMMONS | | | | 18. Mother's Name (First, Middle, Maiden Surname) SWEETIE | | | |
| 19a. Informant's Name/Relationship (Type, Print) 7640 Simmons /son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8629 LUCERNE ROAD Romolston, Md | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN Cemetery | | 20c. Location - City or Town, State 8/25/99 Woodlawn, Maryland | | 20d. Date | |
| 21. Signature of Funeral Service Licensee Jay Harris | | | | 22. Name and Address of Facility CHATHAM - HONORARY FH 5240 RUSTERTON ROAD Baltimore, Md 21215 | | | |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospice: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier Jay Harris | | | | 29c. License number D43725 | | 29d. Date signed (Month, Day, Year) 8/20/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature B. Sparks | | | |

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G774 8-25-99 **Certificate of Death**

Reg. No. 99 26578

| | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) SHERMAN J. NORTON | | | | 2. Date of Death Month Day Year August 18, 1999 | | | | 3. Time of Death 7:20 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number) 1905 Mosher Street | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 217-68-4723 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 42 Yrs. | | 8. Date of Birth (Month, Day, Year) 5-2-57 | | 9. Birthplace (State or Foreign Country) MD. | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD. | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 1905 MOSHER ST. | | | | 10f. Zip Code 21217 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -10- College (1-4 or 5+) -0- | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FORKLIFT OPERATOR | | | | 16b. Kind of Business/Industry DISTRIBUTION | | | |
| 17. Father's Name (First, Middle, Last) EDWARD JONES | | | | 18. Mother's Name (First, Middle, Maiden Surname) DOROTHY NORTON | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) DOROTHY NORTON (MOTHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1905 MOSHER ST. BALTIMORE, MARYLAND 21217 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK | | 20c. Location - City or Town, State BALTIMORE, MARYLAND | | 20d. Date 8-24-99 | | | |
| 21. Signature of Funeral Service Licensee Dorothy Norton | | | | 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NARCOTIC INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) FOUND: 8-18-99 | | 28b. Time of Injury FOUND: 7:10 | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred UNKNOWN | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) RESIDENCE | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1905 MOSHER STREET, BALTIMORE, MD. | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier Theodore M. King | | | | 29c. License number O.C.M.E. | | | | 29d. Date signed (Month, Day, Year) August 19, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26579

| | | | | | | | | | |
|--|---|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary Alma Noble | | | 2. Date of Death Month Day Year AUGUST 20 1999 | | 3. Time of Death 9:00 AM | | | |
| | 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | | | |
| Funeral Director | 5. Social Security Number 212-12-4937 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) March 26, 1920 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Towson | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 106 Kenilworth Park Drive Apt. 2A | | 10f. Zip Code 21204 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 42'-45' | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (14 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse | | 16b. Kind of Business/Industry Medical | | | | |
| | 17. Father's Name (First, Middle, Last) Charles Chlan | | | 18. Mother's Name (First, Middle, Maiden Surname) Matilda Schultz | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Alvin H. Noble/ Husband | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Kenilworth Park Drive Apt. 2A Towson, Md 21204 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens | | 20c. Location - City or Town, State August 24, 1999 Timonium, MD | | | | |
| | 21. Signature of Funeral Service Licensee Michael J. Flagle | | | 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COMA Due to (or as a consequence of): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death UNKNOWN | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DISLOCATION LEFT HIP SEIZURE | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | 29c. License number D26954 | | 29d. Date signed (Month, Day, Year) 08-21-99 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PEMY CHHIM M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature [Signature] | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26580

| | | | | | | | | | | | |
|---|---|---|--|--|--|---------------------------------|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Sonia Osler | | | | 2. Date of Death Month 08 Day 16 Year 99 | | | | 3. Time of Death 7:20pm | | |
| | 4a. Facility Name (If not institution, give street and number) Vantage House Retirement Community | | | | 4b. City, Town, or Location of Death Columbia | | | | 4c. County of Death Howard | | |
| Funeral Director | 5. Social Security Number 220-30-0593 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) 10/10/1912 | | 9. Birthplace (State or Foreign Country) Poland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Md | | 10b. County Howard | | 10c. City, Town or Location Columbia | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 5400 Vantage Point Road #603 | | | | 10f. Zip Code 21044 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Professor | | | | 16b. Kind of Business/Industry University | | | |
| 17. Father's Name (First, Middle, Last) Abraham Fellner | | | | 18. Mother's Name (First, Middle, Maiden Sumama) Anna Goldman | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Abraham G. Osler/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5400 Vantage Point Road #603 Columbia, Md 21044 | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Balto, Washington Crm | | | | 20c. Location - City or Town, State 8/24 Laurel Md | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md 21228 | | | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Urosequin Due to (or as a consequence of): b. Ben Hope Devenors - Mordun Do Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death Days | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number D-34868 | | 29d. Date signed (Month, Day, Year) Aug 17, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Diana Little District PK Columbia, MD 21044 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 10A-F PER MED G775 9-15 **Certificate of Death**

Reg. No. 99 26581

| | | | | | | | | |
|--|--|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DANNIELE D. PRICE | | | | 2. Date of Death Month AUGUST Day 20 Year 1999 | | 3. Time of Death 0021 | |
| | 4a. Facility Name (If not institution, give street and number) 9911 CERVINE LANE APT#2 | | | | 4b. City, Town, or Location of Death RANDALLSTOWN | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 438-19-6226 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 38 Yrs. | | 8. Date of Birth (Month, Day, Year) 11-23-60 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location RANDALLSTOWN | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 307 KEY AVENUE | | 10f. Zip Code 21225 21133 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH GRADE College (14 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ADMINISTRATIVE ASSISTANT | | 16b. Kind of Business/Industry TEMP AGENCY | | 17. Father's Name (First, Middle, Last) SILAS PRICE | | |
| 18. Mother's Name (First, Middle, Maiden Surname) ELAINE HOLLAND | | 19a. Informant's Name/Relationship (Type, Print) SILAS PRICE / FATHER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 KEY AVENUE, BALTO. MD. 21225 | | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) ANNAPOLIS MEMORIAL GARDENS | | 20c. Location - City or Town, State 8/27/99 ANNAPOLIS, MD | | 21. Signature of Funeral Service Licensee Vaughn C. Greene | | 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NAT'L PIKE, BALTO. MD. 21229 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Subarachnoid Hemorrhage Due to (or as a consequence of): Ruptured Berry Aneurysm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | |
| 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Dennis J. Chute, MD | | 29c. License number O.C.M.E | | |
| 29d. Date signed (Month, Day, Year) AUGUST 20, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, MD | | 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature B. Sparks | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

SECRET

172140Z

1 134 3041 1 302 10

2000

1 134 3041 1 302 10

2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26582

AMENDED ITEM #5 PER FH G775 9/13/99 AH
AMEND ITEM: #23 PART 1 PER MEO G774 8-24-99 WR.

| | | | | | |
|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>John</u> | | 2. Date of Death Month <u>August</u> Day <u>9</u> Year <u>1999</u> | | 3. Time of Death <u>10:34pm</u> |
| | 4a. Facility Name (If not institution, give street and number) <u>THE Johns Hopkins Hospital</u> | | 4b. City, Town, or Location of Death <u>Baltimore City</u> | | 4c. County of Death |
| Funeral Director | 5. Social Security Number <u>232-82-8220</u> | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>47</u> Yrs. | If Under 1 Year Months <u>0</u> Days <u>0</u> | If Under 24 Hrs. Hours <u>09</u> Min. <u>24</u> |
| | 8. Date of Birth (Month, Day, Year) <u>09-24-51</u> | | 9. Birthplace (State or Foreign Country) <u>NY</u> | | |
| Usual Residence of Decedent | | | | | |
| 10a. State <u>MD</u> | | 10b. County <u>NA</u> | | 10c. City, Town or Location <u>Baltimore</u> | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number <u>2111 Barclay Street</u> | | | 10f. Zip Code <u>21218</u> | | 10g. Citizen of What Country? <u>USA</u> |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: <u>Black</u> | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>College (14 or 5+)</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business/Industry | |
| 17. Father's Name (First, Middle, Last) <u>William McClelland</u> | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Ann Carper</u> | | |
| 19e. Informant's Name/Relationship (Type, Print) <u>Valeria White</u> | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>21234 1139 Pelham Wood Road Baltimore, Maryland</u> | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Dulaney Valley Cem.</u> | | 20c. Location - City or Town, State <u>08-14-99 Timonium, MD</u> | |
| 21. Signature of Funeral Service Licensee <u>William Edmoff</u> | | 22. Name and Address of Facility <u>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</u> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line: <u>MASSIVE PULMONARY HEMORRHAGE</u> | | | | | |
| Approximate Interval Between Onset and Death <u>1 HOUR</u> | | | | | |
| Immediate Cause (Final disease or condition resulting in death) <u>Asphyxiation</u> | | | | | |
| Due to (or as a consequence of): <u>METASTATIC SQUAMOUS CELL CANCER</u> | | | | | |
| 2 YEARS | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Massive Pulmonary Hemorrhage</u> | | | | | |
| Due to (or as a consequence of): <u>T4 N2c M1 OROPHARYNX SQUAMOUS CANCER</u> | | | | | |
| 2 YEARS | | | | | |
| Due to (or as a consequence of): <u>Metastatic Squamous Cell CARCINOMA</u> | | | | | |
| 2 YEARS | | | | | |
| Due to (or as a consequence of): <u>T4 N2c M1 OROPHARYNX SQUAMOUS CELL CANCER</u> | | | | | |
| 2 YEARS | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <u>M</u> | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <u>Charles C. Della Santina M.D.</u> | | 29c. License number <u>RES-000</u> | | 29d. Date signed (Month, Day, Year) <u>8/9/1999</u> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Johns Hopkins Hospital</u> <u>Charles C. Della Santina M.D.</u> <u>600 Wolfe Street Baltimore</u> | | | | | |
| 31. Date filed (Month, Day, Year) <u>AUG 24 1999</u> | | 32. Registrar's Signature <u>Seneca B. Sparks</u> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

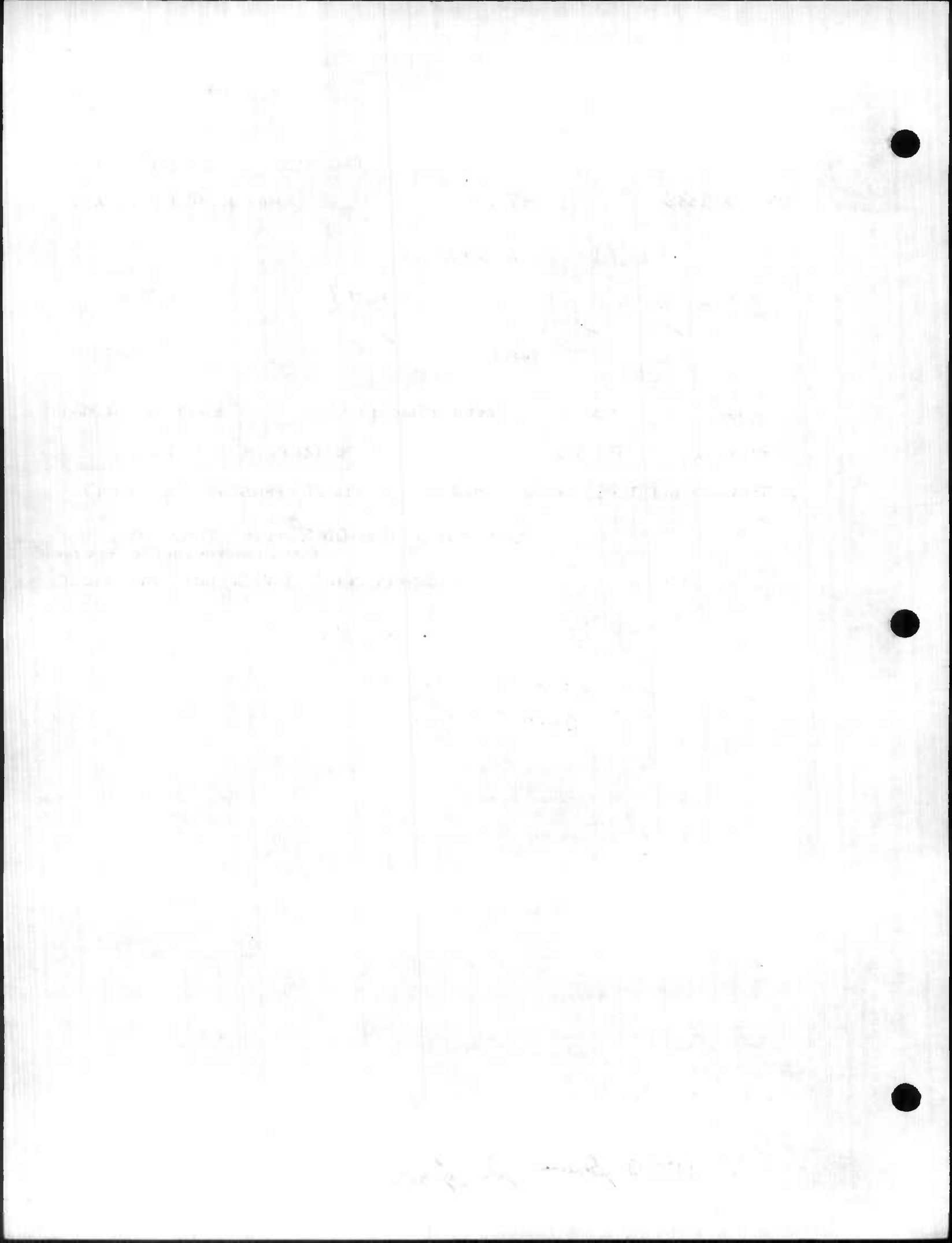
Reg. No. 99 26583

| | | | | | | | | | | | | |
|--|---|--|---|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Kevin A. Peters</u> | | | | 2. Date of Death Month <u>Aug</u> Day <u>23</u> Year <u>1999</u> | | | | 3. Time of Death <u>8:45 AM</u> | | | |
| | 4a. Facility Name (If not Institution, give street and number) <u>2902 Sedgefield Ct.</u> | | | | 4b. City, Town, or Location of Death <u>FALLSTON</u> | | | | 4c. County of Death <u>HARFORD</u> | | | |
| Funeral Director | 5. Social Security Number <u>330-42-9338</u> | | 8. Sex <u>M</u> <input checked="" type="checkbox"/> <u>F</u> <input type="checkbox"/> | | 7. Age (In yrs. last birthday) <u>45</u> Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | | |
| | Usual Residence of Decedent | | | | 6. Date of Birth (Month, Day, Year) <u>MAY 20, 1954</u> | | 9. Birthplace (State or Foreign Country) <u>ILLINOIS</u> | | | | | |
| To Be Completed by Funeral Director | 10a. State <u>Md</u> | | 10b. County <u>HARFORD</u> | | 10c. City, Town or Location <u>FALLSTON</u> | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number <u>2902 Sedgefield Ct.</u> | | | | 10f. Zip Code <u>21047</u> | | | | 10g. Citizen of What Country? <u>U.S.A.</u> | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>ARMY</u> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u> | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>+4</u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>HELICOPTER PILOT</u> | | | | 16b. Kind of Business/Industry <u>BALTIMORE CITY POLICE</u> | | | |
| | 17. Father's Name (First, Middle, Last) <u>ANDREW PETERS</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>ELIZABETH TILL</u> | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) <u>M. J. GEORGE C. PETERS, SPOUSE</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2902 SEDGEFIELD CT. FALLSTON, MD. 21047</u> | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>DULANEY VALLEY MEM. GNS.</u> | | | | 20c. Location - City or Town, State <u>1999 TIMONIUM, MD.</u> | | | |
| | 21. Signature of Funeral Service Licensee <u>Krista S. Wells</u> | | | | 22. Name and Address of Facility <u>EVANS FUNERAL CHAPEL - BEL AIR</u> <u>3 NEWPORT DRIVE FOREST HILL, MD. 21050</u> | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Meningeal carcinomatosis</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Malignant melanoma</u> <u>Brain metastases</u> | | | | | | | | Approximate Interval Between Onset and Death <u>2 months</u> <u>10 years</u> <u>11 months</u> | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Lung metastases</u> <u>Liver metastases</u> | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <u>Dr. Rodrigo E. Elich</u> | | | | 29c. License number <u>D0054911</u> | | 29d. Date signed (Month, Day, Year) <u>08-23-99</u> | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Dr. Rodrigo Elich Johns Hopkins Bayview</u> | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) <u>AUG 24 1999</u> | | | | 32. Registrar's Signature <u>B. Sparks</u> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26584

| | | | | | | | | | | |
|--|--|--|---|---|---|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Thomas James Preziosi | | | | | | 2. Date of Death Month Day Year August 14, 1999 | | 3. Time of Death 7:37 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) University of Maryland, Shock Trauma | | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 215-34-5811 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | | 8. Date of Birth (Month, Day, Year) August 30, 1924 | | 9. Birthplace (State or Foreign Country) Canada | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md | | 10b. County Baltimore | | 10c. City, Town or Location Parkville | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 3026 Oak Crest Ave. | | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Neurologist | | | 16b. Kind of Business/Industry Johns Hopkins Hospital | | |
| | 17. Father's Name (First, Middle, Last) Frederick Preziosi | | | | 18. Mother's Name (First, Middle, Maiden Surname) Catherine Johni | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Perella Preziosi | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3026 Oak Crest Ave. Baltimore, Md 21234 | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel - Bel Air | | | | 20c. Location - City or Town, State Forest Hill, Md | | 20d. Date Aug 18 1999 | |
| | 21. Signature of Funeral Service Licensee Christa S. Wells | | | | 22. Name and Address of Facility Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries with Complications Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| State Registrar | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| | 24a. Was an autopsy performed? Approval <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 07-16-1999 | | 28b. Time of Injury 11:10 AM | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject was a passenger in a car which struck a tree and overturned. | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) Manor Rd. nr. Glen Arm Rd., Glen Arm, Maryland. | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier M Neal Reynolds MD | | | | 29c. License number D27163 | | 29d. Date signed (Month, Day, Year) August 18, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Neal Reynolds, R. Adams Cowley Shock Trauma Ctr, 22 S. Greene St., Balto., MD | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | |

ORIGINAL

W

Jim [unclear] [unclear]

SEP 1 3 00A

99-4623-510
B.K.S
MARK R. PENN

AMEND #10b-10F PER F.H. G774 8-24-99 J.A.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND #23 PRT I&!! 27,28a-f PER MEO G774 8-24-99 J.A.

Certificate of Death

Reg. No.

99 26585

| | | | | | | | | | | | | | | | |
|---|---|---|---|--|---|--|---|--|--|---|--|---|--------------------------------|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARK ROBERT PENN | | | | 2. Date of Death Month Day Year AUG. 9, 1999 | | | | 3. Time of Death 2:07 AM | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 901 SOUTH EAST AVENUE | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death N/A | | | | | | |
| Funeral Director | 5. Social Security Number 213-80-7601 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 39 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 18, 1959 | | 9. Birthplace (State or Foreign Country) Maryland | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Bel Air BALTIMORE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| | 10e. Street and Number 901 S. EAST AVENUE 904 E. Martell Court | | | | 10f. Zip Code 21014 21224 | | 10g. Citizen of What Country? U.S.A. | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade | | | | 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telemarketer | | | 15b. Kind of Business/Industry Communications Co. | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Charles Anthony Penn | | | | 18. Mother's Name (First, Middle, Maiden Surname) Frances Kay Blanchard | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Charles A. Penn (Father) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 E. Martell Court, Bel Air, MD. 21014 | | | | | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory | | 20c. Date 8/13/99 | | 20d. Location - City or Town, State Baltimore, Maryland | | | | | | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014 | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NARCOTIC INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death | | | | |
| | Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COCAINE USE | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 8-9-99 | | 28b. Time of Injury FOUND 12:10 | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred UNKNOWN | | | | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 901 S. EAST AVE. BALTIMORE CITY, MD. | | | | | | | | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. Signature and title of certifier | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) AUG. 9, 1999 |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26586

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Roberta Marion Paul

2. Date of Death

Month Day Year
August 20, 1999

3. Time of Death

7:50 PM

4e. Facility Name (If not institution, give street and number)

8518 Wind Dance Way

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

578-09-9021

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
September 21, 1917

9. Birthplace (State or Foreign Country)

Washington D. C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

8518 Wind Dance Way

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Robert Nash Jones

18. Mother's Name (First, Middle, Maiden Surname)

Verna Amanda McClintock

19a. Informant's Name/Relationship (Type, Print)

Mr. Rick Bennett

Personal Rep

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1635 German Chaper Road Prince Frederick, Maryland 20678

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

08/23/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

► Kim McCall mol201

22. Name and Address of Facility

Slack Funeral Home, P.A.

3871 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Due to (or as a consequence of):

chronic obstructive pulmonary disease

Approximate Interval Between Onset and Death

15 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Gary A. Milles MD

29c. License number

D26621

29d. Date signed (Month, Day, Year)

August 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Milles, Gary A. MD 3460 Ellicott Center Drive, Suite 103 Ellicott City, MD 21043

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

► Denise S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26507

| | | | | | | | | |
|--|---|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GLADYS V. ROWLETTE | | | | 2. Date of Death Month Day Year AUGUST 17 1999 | | 3. Time of Death 14:05 PM | |
| | 4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 215-16-9926 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 11-22-22 | 9. Birthplace (State or Foreign Country) N.C. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD. | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 3915 CALLOWAY AVE. APT. 604 | | | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12- College (1-4 or 5+) -0- | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC | | 16b. Kind of Business/Industry HOUSEWIFE | | |
| 17. Father's Name (First, Middle, Last) FRENCH WILLIAMS | | | | 18. Mother's Name (First, Middle, Maiden Surname) HERNE HARTFIELD | | | | |
| 19a. Informant's Name/Relationship (Type, Print) SHEILA MORSLEY (GRAND DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2539 PARK HEIGHTS TERRACE BALTIMORE, MARYLAND 21215 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge | | 20c. Date 8-23-99 | | 20d. Location - City or Town, State BALTIMORE, MARYLAND | |
| 21. Signature of Funeral Service Licensee Doretha Hector | | | | 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ischaemic Cardiomyopathy Due to (or as a consequence of): b. Empyema Due to (or as a consequence of): c. Hypotension Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 10 days 10 days 10 days |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. old CVA | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Doretha Puthumana, MD | | | | 29c. License number AT 2438946 | | 29d. Date signed (Month, Day, Year) AUGUST, 17, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION MEMORIAL HOSPITAL, LOREEN PUTHUMANA, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature B. Sparks | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

10-11-64

John A. Smith

ALB 1 3 01A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26588

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS ROBINSON

2. Date of Death

Month

Day

Year

3. Time of Death

3:45pm

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

217-24-1865

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

08 27 31

9. Birthplace (State or Foreign Country)

M.D.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

124 West Franklin St Apt 1008

10f. Zip Code

21201

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th grade

College (1-4or 5+)

na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

Morgan State College

17. Father's Name (First, Middle, Last)

Thomas L. robinson

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Charlena Scribner-Daughter 2801 Allendale Road, Baltimore Md 21216

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Western Star Cemetery 8/25/99 Baltimore, md

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Gabrielle Corn

22. Name and Address of Facility

March F/H WEST

4300 Wabash Ave, Baltimore Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

SEPSIS

Due to (or as a consequence of):

b.

ANEMIA

Due to (or as a consequence of):

c.

CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Saba, MD

29c. License number

P11781

29d. Date signed (Month, Day, Year)

8/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOANNA M. SABA, MD, 22 S. GREENE ST, BALTO, MD 21201

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at (410) 326-6000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

RECEIVED 11-11-71

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible. It appears to be a memorandum or report detailing an investigation or administrative action. Key words that are partially visible include "New York", "Bureau", "information", "report", "action", "recommendation", "approval", "disapproval", "comment", "conclusion", "summary", "details", "background", "history", "status", "progress", "results", "findings", "analysis", "evaluation", "assessment", "recommendations", "conclusions", "summary", "details", "background", "history", "status", "progress", "results", "findings", "analysis", "evaluation", "assessment".]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26589

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

David Brian Ruhl

2. Date of Death
Month Day Year
Aug. 21, 19993. Time of Death
8:30 pmFuneral
Director

4a. Facility Name (If not institution, give street and number)

3339 Rogers Avenue

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

5. Social Security Number

218.74.7847

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

41 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 7, 1958

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1□ Yes 2~~□~~ No

10e. Street and Number

3339 Rogers Avenue

10f. Zip Code

21043

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Never Married 2□ Married
3□ Widowed 4~~□~~ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1□ Yes 2~~□~~ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1□ Yes 2~~□~~ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Computers

16b. Kind of Business/Industry

CSX Railroad

17. Father's Name (First, Middle, Last)

Robert C. Ruhl

18. Mother's Name (First, Middle, Maiden Surname)

Edith Benson

19a. Informant's Name/Relationship (Type, Print)

Kathy Baer /Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3339 Rogers Avenue Ellicott City, MD 21043

20a. Method of Disposition

1□ Burial 2~~□~~ Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Baltimore Washington 8/23

Date

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

Kathy M. Peters

22. Name and Address of Facility

Sterling-Ashton-Schwab
736 Edmondson Ave. Catonsville, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. END STAGE HUNTINGTONS CHOREA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

6 MONTHS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4~~□~~ Unknown24a. Was an autopsy
performed?1□ Yes 2~~□~~ No24b. Were autopsy findings
available prior to
completion of cause
of death?1□ Yes 2~~□~~ No25. Was case referred to medical
examiner?
1□ Yes 2~~□~~ No

26. Place of Death (Check only one)

Hospital: 1□ Inpatient 2□ ER/Outpatient 3□ DOA Other: 4~~□~~ Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1□ Natural 5□ Pending
Investigation
2□ Accident 6□ Could not be
determined
3□ Suicide
4□ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1~~□~~ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Deborah I. Pierce

29c. License number

H45931

29d. Date signed (Month, Day, Year)

August 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah I. Pierce 7220 Park Heights Ave Balto. MD 21208

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

Jenna B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26590

| | | | | | | | | | | |
|---|---|---|--|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Parvin Riddle | | | | 2. Date of Death Month Day Year August 21, 1999 | | | | 3. Time of Death 1400 | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 039-20-0651 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 69 Yrs. | | 8. Date of Birth (Month, Day, Year) April 2 1930 | | 9. Birthplace (State or Foreign Country) Massachusetts | |
| | Usual Residence of Decedent | | | | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Annapolis | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 111 Silopanna | | | | 10f. Zip Code 21403 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korean | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner | | | | 16b. Kind of Business/Industry Electronics | | |
| 17. Father's Name (First, Middle, Last) Ralph Riddle | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lucia Parvin | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ralph Riddle - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 924 King James Landing, Annapolis, MD 21403 | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date 8/23 | | 20c. Location - City or Town, State Baltimore, MD | | | | |
| 21. Signature of Funeral Service Licensee <i>Ralph Riddle</i> | | | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Uroinfection</i> Due to (or as a consequence of): b. <i>Pneumonia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 5 days 5 days | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CVA (Cerebral vascular accident) 1989</i> <i>Suzanne Disorder 1989</i> | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | |
| 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of Certifier <i>Peter Stengel MD</i> | | | | 29c. License number D0053277 | | |
| 29d. Date signed (Month, Day, Year) 8/21/99 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 472 Spa Rd. Annapolis MD 21403 Peter Stengel MD | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature <i>G. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar

Handwritten text, mostly illegible due to extreme fading. The text appears to be organized into several paragraphs or sections, possibly separated by horizontal lines. The handwriting is cursive and somewhat slanted. There are three distinct black circular marks on the right edge of the page, which appear to be punch holes or binder marks.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26591

| | | | | | | | | |
|--|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert A. RAGAN | | | | 2. Date of Death Month Day Year AUGUST 21 1999 | | 3. Time of Death 7:30 PM | |
| | 4a. Facility Name (If not institution, give street and number) FRANKLIN WOODS NURSING HOME | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 212-01-7445 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) SEPT 30, 1916 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location PARKVILLE | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 2607 HILLCREST AVE | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOME IMPROVEMENT | | 16b. Kind of Business/Industry SELF | | | | |
| 17. Father's Name (First, Middle, Last) ALLEN RAGAN | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNA ZAHN | | | | |
| 19a. Informant's Name/Relationship (Type, Print) BETTY ANNE POOLE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 422 LINWOOD AVE, BELAIR MD 21014 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MORELAND CEMETERY | | 20c. Location - City or Town, State 8/25/99 BALTO. MD | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility HARTLEY MILLER FUNERAL HOME CHTD. 7527 HARFORD RD. BALTO. MD 21234 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Recurrent Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death 14 mo. | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier M.D. | | 29c. License number D 45390 | | 29d. Date signed (Month, Day, Year) 8/23/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6830 HOSPITAL DR # 206, BALTIMORE, MD 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26592

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Slifer

2. Date of Death

Month 8 Day 22 Year 99

3. Time of Death

10:03am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Futurecare Homewood

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

City

5. Social Security Number

211 015608

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 9/13/19

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

H/n

10c. City, Town or Location

Baltimore

10d. Inside City Limits

Yes ☒ No ☐

10e. Street and Number

733 Exeter Hall Ave

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 YEAR

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

GRINDER

16b. Kind of Business/Industry

ARCO STEEL

17. Father's Name (First, Middle, Last)

William Harley Slifer

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Irene Burwinkel

19a. Informant's Name/Relationship (Type, Print)

PAUL SLIFER BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5919 DOLYN DRIVE Ethel Park, Pa 15102

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Cemetery

Date

8/24/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CRATIAN - HARRIS F.H. 5240 KIRSTENBACH ROAD BALTIMORE, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Decompensated Congestive heart failure

Due to (or as a consequence of):

b. Cardiomyopathies

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. [Blank]

Due to (or as a consequence of):

d. [Blank]

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

170 Acute Myocardial infarction;
Atherosclerotic Cardiovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicida 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D17537

29d. Date signed (Month, Day, Year)

8-23-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR DARSHAN S. SALUJA MD 1600 W. MOUNT Royal Ave, Balto 21217

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26593

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD E. SHETRONE, SR.

2. Date of Death

AUGUST 22 1999

3. Time of Death

2:25 PM.

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH OF NORTH ARUNDEL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL CO.

Funeral
Director

5. Social Security Number

212-01-2425

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 11 1912

9. Birthplace (State or Foreign Country)

York, Penna.

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1100 Church Street

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Guard

16b. Kind of Business/Industry

B.G. & E.

17. Father's Name (First, Middle, Last)

John Shetrone, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Strickler

19a. Informant's Name/Relationship (Type, Print)

Richard E. Shetrone, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14007 Old Hanover Road, Reisterstown, Md. 21136

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Holy Cross Cemetery

Date

8/26/99

20c. Location - City or Town, State

Brooklyn Park, Md.

21. Signature of Funeral Service Licensee

Kevin E. Ecker

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.

237 E. Patapsco Ave., Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Prostate Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D50725

29d. Date signed (Month, Day, Year)

8/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jennifer Riedinger MD 479 Jumpers Hole Rd. Severna Park MD 21146

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26594

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

GERTRUDE ROSETTA SCHUMAN

2. Date of Death

Month Day Year

AUGUST 20 1999

3. Time of Death

12:10 am

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

3001 SOUTH HANOVER STREET

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

n/a

5. Social Security Number

217-34-9302

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 10 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

600 Light Street Apt. #210

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home Owner

17. Father's Name (First, Middle, Last)

Joseph H. Carrick

18. Mother's Name (First, Middle, Maiden Surname)

Elsie M. Adams

19a. Informant's Name/Relationship (Type, Print)

William E. Schuman (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

163 Kenwood Road Rivera Beach, Md. 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

8/23/99

20c. Location - City or Town, State

Brooklyn Park, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.

130 E. Fort Ave., Baltimore, Md. 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ATRIAL FIBRILLATION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

TEN DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL CELL CARCINOMA OF RIGHT KIDNEY

WITH LUNG METASTASES

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

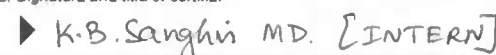
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

AS2441614A48

29d. Date signed (Month, Day, Year)

AUGUST 20th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAVITA BADAL SANGHVI, 309-F LIMESTONE VALLEY DRIVE, COCKEYSVILLE, MD-21030

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AM8

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26595

| | | | | | | | |
|--|---|--|--|---|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harry W. Schuman | | | 2. Date of Death Month 8 Day 19 Year 1999 | | 3. Time of Death 7:25 PM | |
| | 4a. Facility Name (If not institution, give street and number) North Arundel Hospital | | | 4b. City, Town, or Location of Death Glen Burnie | | 4c. County of Death Anne Arundel Co. | |
| Funeral Director | 5. Social Security Number 212-01-3755 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) April 2, 1911 |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10. Inside City Limits 1 Yes 2 No | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Anne Arundel Co. | | 10c. City, Town or Location Pasadena | | 10d. Inside City Limits 1 Yes 2 No |
| | 10e. Street and Number 8140 Forest Glen Drive | | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) + 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Paddy Wagon Driver | | 16b. Kind of Business/Industry Baltimore City Police Dept. | | |
| | 17. Father's Name (First, Middle, Last) George A. Schuman | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Bishop | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Judith A. Bortner Niece | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8075 Forest Glen Drive Pasadena, Maryland 21122 | | | |
| | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Park | | 20c. Date Aug. 23, 1999 | | 20d. Location - City or Town, State Glen Burnie, Maryland |
| | 21. Signature of Funeral Service Licensee Christina A. Hilton | | | 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death) a. Anterior Septal Myocardial Infarction Due to (or as a consequence of): b. Chronic Atrial Fibrillation Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bradycardia and Pacemaker | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown |
| | 24a. Was an autopsy performed? 1 Yes 2 No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |
| | 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | |
| | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | |
| | 29b. Signature and title of certifier Christopher deBorja M.D. | | 29c. License number 042820 | | 29d. Date signed (Month, Day, Year) 8/19/99 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher deBorja M.D. 3708 Mountain Rd., Pasadena, Md. 21122 | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature James B. Sparks | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26596

| | | | | | | | | |
|---|--|---|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILLIAM ANDREW STEPCICH | | | | 2. Date of Death Month Day Year AUGUST 23, 1999 | | 3. Time of Death 02:45 PM | |
| | 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 216-05-7205 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 22, 1905 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 5507 Plainfield Avenue | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? U. S. A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) 8th Grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Officer | | 16b. Kind of Business/Industry Baltimore City Government | | 17. Father's Name (First, Middle, Last) Anton Stepcich | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Mary Zitnik | | 19a. Informant's Name/Relationship (Type, Print) Joseph A. Stepcich (Son) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Stonehurst Road, Phoenix, Maryland 21131 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer | | 20c. Location - City or Town, State Baltimore, Maryland | | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): HYPONATREMIA Due to (or as a consequence of): DEHYDRATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death 1 WEEK 1 MONTH | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal | | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28b. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Natividad D. de Leon, M.D. | | |
| 29c. License number D 19508 | | 29d. Date signed (Month, Day, Year) August 23, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIVIDAD D. DE LEON, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204 | | 31. Date filed (Month, Day, Year) AUG 24 1999 | | |
| 32. Registrar's Signature  | | State Registrar | | DHMH 16 Rev 6/95 | | A145 | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

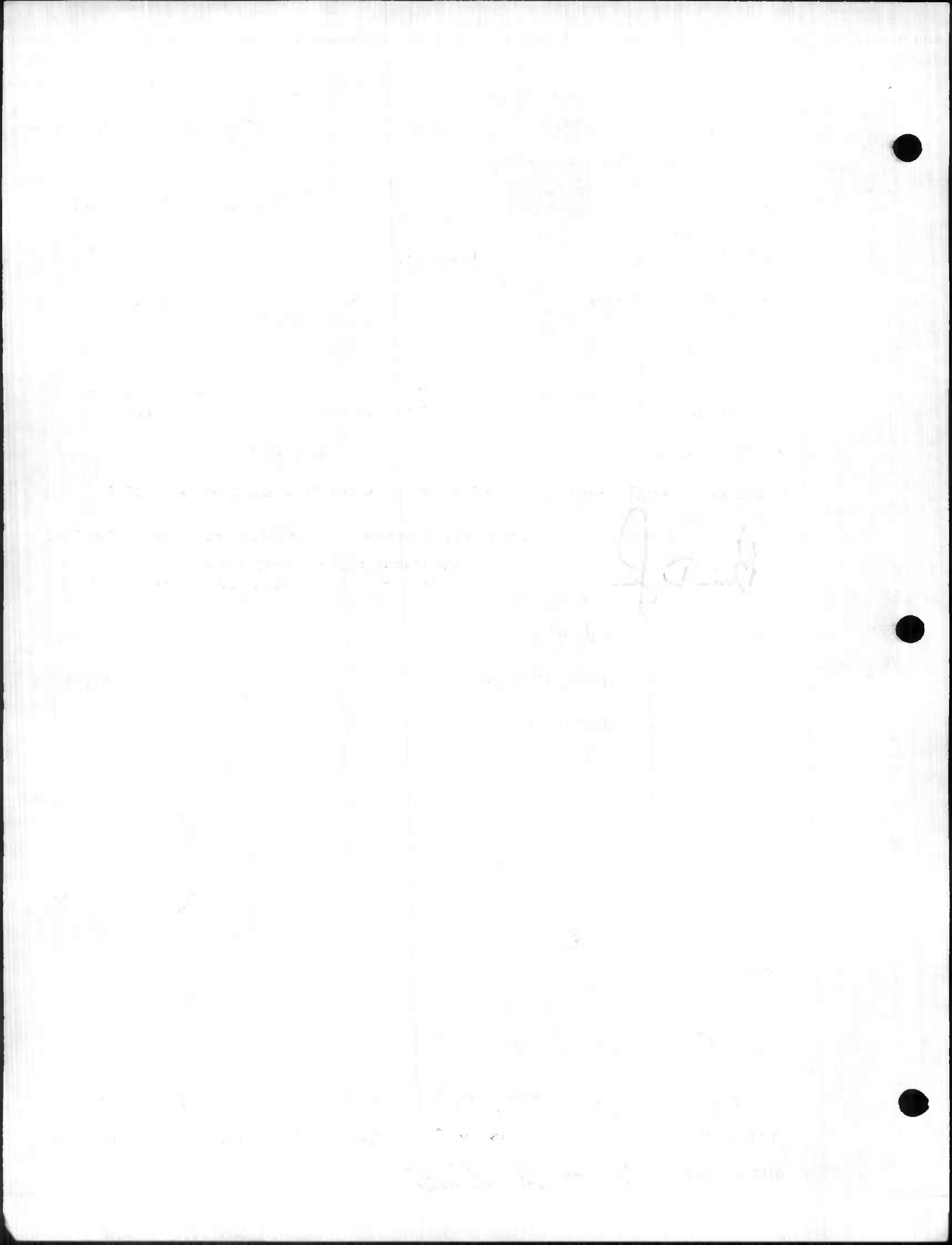
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26597

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Otto Adam Schaub

2. Date of Death

Month Day Year
JULY 20 1999

3. Time of Death

8:20 PM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-14-8963

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 24, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3513 Harford Road

10f. Zip Code

21218

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Steel Company

17. Father's Name (First, Middle, Last)

William Schaub

18. Mother's Name (First, Middle, Maiden Surname)

Martha Kimmel

19a. Informant's Name/Relationship (Type, Print)

Audrey Bopp (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

431 W. Maple Road, Lithicum, Maryland 21090

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Loudon Park

Date

8/23/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Beverly A. Uehlein

22. Name and Address of Facility

Schimunek Funeral Home Inc.
3331 Brehms Lane, Baltimore, Maryland 2121323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. metastatic small cell lung cancer

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

13 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

m.w.

29c. License number

044944

29d. Date signed (Month, Day, Year)

August 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stanley Walker 3333 North Calvert Street Baltimore, MD 21218

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

Beverly A. Uehlein

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26598

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel G. Starr

2. Date of Death

Month Day Year
AUGUST 21, 1999

3. Time of Death

22:53 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-18-8005

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 2 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12-6-24

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4810 Ridge Road

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12 years

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Neely

18. Mother's Name (First, Middle, Maiden Surname)

Genieve Seufert

19a. Informant's Name/Relationship (Type, Print)

Karen Schreiber (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4400 Quaker Hills Ct., Havre de Grace, MD 21078

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Baltimore Cemetery

Date

Aug. 24, 1999

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Maib T. [Signature]

22. Name and Address of Facility

Schimunek Funeral Home, Inc.

9705 Belair Road, Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

EMBOLIC RIGHT CEREBROVASCULAR ACCIDENT WITH

Approximate
Interval Between
Onset and Death
24 HOURS

a. Due to (or as a consequence of):

DEHYDRATION WITH INCREASE BUN AND CREATINE

3 DAYS

b. Due to (or as a consequence of):

CHRONIC ATRIAL FIBRILLATION

YEARS

c. Due to (or as a consequence of):

HEMICOLECTOMY SECONDARY TO MESENTERIC EMBOL

3 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ELECTROLYTE IMBALANCE

HYPOPROTEINEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier

(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ceballos, my

29c. License number

D-25886

29d. Date signed (Month, Day, Year)

Aug. 21.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LILIA CEBALLOS, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
90058.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26599

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Lucille Clara Steinacker

2. Date of Death

Month Day Year
August 20 1999

3. Time of Death

0017

4a. Facility Name (If not institution, give street and number)

ST AGNES HOSPITAL, 900 CATON AVE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

216-16-0725

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 11, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

621 Southmont Road

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

William A. Owens

18. Mother's Name (First, Middle, Maiden Summa)

Selma Eversmeier

19a. Informant's Name/Relationship (Type, Print)

Norbert E. Steinacker/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

621 Southmont Rd. Catonsville, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Old Salem Cemetery

Date

08/23/99

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Employee

Dawn F. McDonald

22. Name and Address of Facility

MacNabb Funeral Home, P.A.
301 Frederick Rd. Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Renal Cell Sarcoma

Due to (or as a consequence of):

b.

Lung metastasis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

3-4 wks

3-4 wks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accidental 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mustapha Mallah

29c. License number

P12595

29d. Date signed (Month, Day, Year)

August - 20 - 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mustapha Mallah

900 Caton Ave. Baltimore, MD 21229

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME

Steinacker, Lucille

State

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26600

| | | | | | | | | |
|---|--|---|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Annie Rebecca Smith | | | | 2. Date of Death Month Day Year AUG 21, 1999 | | 3. Time of Death 8:00am | |
| | 4a. Facility Name (If not institution, give street and number) Sweet Rest and Care | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 214-16-6440 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN 03, 1915 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 3406 Callaway Avenue | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laundry Worker | | 16b. Kind of Business/Industry Dry Cleaners | | | | |
| 17. Father's Name (First, Middle, Last) Unk. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Unk. | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Delores R. Quick/granddaughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2537 Cedar Drive Baltimore, MD 21207 | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | 20c. Location - City or Town, State 08/23/99 Baltimore, MD | | | | |
| 21. Signature of Funeral Service Licensee Dawn F. McDonald | | 22. Name and Address of Facility Cremation Society of Md., Inc. 299 Frederick Rd. Baltimore, MD 21228 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Thyroid Mass Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension Dementia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Dementia | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Don Bousal | | | | 29c. License number D36353 | | 29d. Date signed (Month, Day, Year) 8/23/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don Bousal 2411 W. Belvedere Ave Pk 145 MD 21207 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature Benjamin B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26601

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|--|---------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last) <i>Angelina M. Sedar</i> | | | | 2. Date of Death Month <i>August</i> Day <i>19</i> Year <i>1999</i> | | 3. Time of Death <i>7:45pm</i> | |
| 4a. Facility Name (If not institution, give street and number) <i>8 G Lockhart Circle</i> | | | | 4b. City, Town, or Location of Death <i>Forest Hill</i> | | 4c. County of Death <i>Hartford</i> | |
| 5. Social Security Number <i>192-14-2468</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>75</i> Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours | 8. Date of Birth Month, Day, Year <i>March 13 1924</i> | 9. Birthplace (State or Foreign Country) <i>Pennsylvania</i> |
| Usual Residence of Decedent | | | | | | | |
| 10a. State <i>Md</i> | | 10b. County <i>Hartford</i> | | 10c. City, Town or Location <i>Forest Hill</i> | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number <i>8 B Lockhart Circle</i> | | | | 10f. Zip Code <i>21050</i> | | 10g. Citizen of What Country? <i>USA</i> | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>sales clerk</i> | | 16b. Kind of Business/Industry <i>department store</i> | |
| 17. Father's Name (First, Middle, Last) <i>Antonio Anioia</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Mieracki</i> | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Tom Whiteleather</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>431 Wellcrest Dr. Forest Hill, Md 21050</i> | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>St. Peters Cemetery</i> | | 20c. Location - City or Town, State <i>Mt. Carmel, Pennsylvania</i> | | 20d. Date <i>Aug 23 1999</i> | |
| 21. Signature of Funeral Service Licensee <i>Kirk S. Wells</i> | | | | 22. Name and Address of Facility <i>Evans Funeral Chapel - Bel Air 3 Newport Dr. Forest Hill, Md 21050</i> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>HASCD</i> Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier <i>Ganesh Prabh</i> | | | | 29c. License number <i>OCMB</i> | | 29d. Date signed (Month, Day, Year) <i>Aug 19 1999</i> | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Dr. Ganesh Prabh 218 Fulford Ave. Bel Air, Md</i> | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>AUG 24 1999</i> | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | |

Baltimore, Maryland 21215-0020

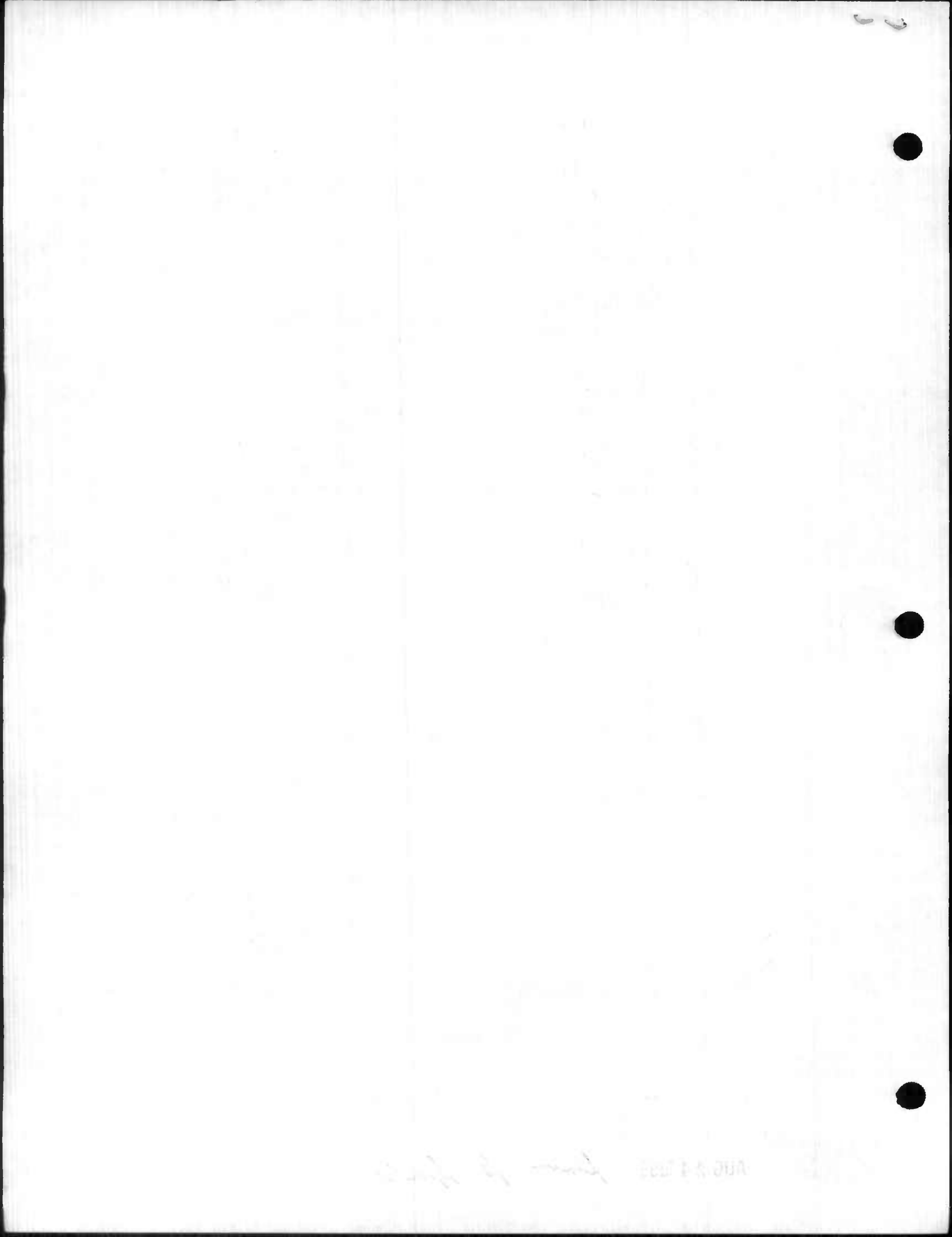
Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
Examiner

State
Registrar



12-1-50

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26602

| | | | | | | | | |
|---|---|---|--------------------------|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Beatrice Smith | | | | 2. Date of Death Month Aug Day 14 Year 1999 | | 3. Time of Death 8:10 pm | |
| | 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 212-28-9091 | | 6. Sex 1 M 2 F | 7. Age (In yrs. last birthday) 72 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) NOV 11 1927 | 9. Birthplace (State or Foreign Country) MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | | | 10d. Inside City Limits Yes 2 No | |
| 10e. Street and Number 1100 N KENWOOD AVENUE | | | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC ENGINEER | | | 16b. Kind of Business/Industry GOVERNMENT | |
| 17. Father's Name (First, Middle, Last) HORACE FOSTER | | | | 18. Mother's Name (First, Middle, Maiden Surname) ALBERTA COFFIELD | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Charles U. Smith/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 N. Kenwood Avenue, Baltimore, Maryland 21213 | | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) HOLLY HILLS CEMETERY | | Date 8-21-99 | 20c. Location - City or Town, State MIDDLE RIVER, MARYLAND | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) a. Ventricular Fibrillation | | | | | | | | ~30 minutes |
| Due to (or as a consequence of): b. Myocardial Infarction | | | | | | | | 1-2 hours |
| Due to (or as a consequence of): c. Coronary Artery Disease | | | | | | | | Years |
| Due to (or as a consequence of): d. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown |
| 24a. Was an autopsy performed? 1 Yes 2 No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) | | | | |
| 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number D41128 | | 29d. Date signed (Month, Day, Year) August 20, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARJUN CHANMUGAM S.H.U. BALTO. MD 21205 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26603

| | | | | | | | | | |
|--|---|---|--|---|---|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Herbert Small</i> | | | | 2. Date of Death Month <i>Aug</i> Day <i>22</i> Year <i>1999</i> | | 3. Time of Death <i>2:40pm</i> | | |
| | 4a. Facility Name (If not institution, give street and number) <i>Northwest Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>Baltimore</i> | | |
| Funeral Director | 5. Social Security Number <i>216-31-7177</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>56</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>May 2, 1943</i> | | |
| | 9. Birthplace (State or Foreign Country) <i>Jamaica</i> | | 10a. State <i>MD</i> | | 10b. County <i>NA</i> | | 10c. City, Town or Location <i>Baltimore</i> | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number <i>5301 Hawlin Ave.</i> | | 10f. Zip Code <i>21215</i> | | 10g. Citizen of What Country? <i>U.S.A</i> | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th</i> College (1-4 or 5+) <i>N/A</i> | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Factory Worker</i> | | 16b. Kind of Business/Industry <i>unk</i> | | 17. Father's Name (First, Middle, Last) <i>Elv Small</i> | | 18. Mother's Name (First, Middle, Maiden Surname) <i>unk</i> | | 19a. Informant's Name/Relationship (Type, Print) <i>Delceta A. Small-wife</i> | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5301 Hawlin Ave. Balt. Md. 21215</i> | | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus Glen Park</i> | | 20c. Date <i>8-28-99</i> | | 20d. Location - City or Town, State <i>Balto Md</i> | |
| 21. Signature of Funeral Service Licensee <i>Phyllis B. Harris</i> | | 22. Name and Address of Facility <i>March Funeral Home West, Inc. 4300 Wabash Ave. Balto Md 21215</i> | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute Encephalopathy</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death <i>4 days</i> | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Phyllis B. Harris</i> | | 29c. License number <i>H 43974</i> | |
| 29d. Date signed (Month, Day, Year) <i>August 22, 1999</i> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Alice Harris Northwest Hospital Randallstown, MD</i> | | 31. Date filed (Month, Day, Year) <i>AUG 24 1999</i> | | 32. Registrar's Signature <i>Phyllis B. Harris</i> | | | |

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

jhm
CHARLES
SCHNEIDER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26604

| | | | | | | | | |
|--|--|---|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CHARLES SCHNEIDER | | | | 2. Date of Death Month Day Year AUGUST 22, 1999 | | 3. Time of Death 04:51 AM | |
| | 4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 104-30-0729 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 59 Yrs. | | 8. Date of Birth (Month, Day, Year) 5/17/1940 | |
| | 9. Birthplace (State or Foreign Country) NEW YORK | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location CARNEY | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 12 B FITZGERALD COURT | | 10f. Zip Code 21234 | | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 YEARS | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CAR SALESMAN | | 16b. Kind of Business/Industry TONY KELLYS | | |
| 17. Father's Name (First, Middle, Last) UNAVAILABLE | | | | 18. Mother's Name (First, Middle, Maiden Surname) UNAVAILABLE | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MARLENE CONLEY GIRLFRIEND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 B FITZGERALD COURT BALTIMORE, MD 21234 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY, INC. | | Date 8/24/99 | | 20c. Location - City or Town, State CATONSVILLE, MD | | |
| 21. Signature of Funeral Service Licensee <i>Heather N. Hayes</i> | | | | 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <i>Dr. Peem</i> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Heather N. Hayes</i> | | | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) AUGUST 22, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEATHER N. HAYES 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26605

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Theresa M. Stith</u> | | | | 2. Date of Death Month <u>8</u> Day <u>17</u> Year <u>99</u> | | 3. Time of Death <u>5:00 AM</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>3022 Baker St.</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>N/A</u> | |
| Funeral Director | 5. Social Security Number <u>215-18-5806</u> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>78</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>02 11 21</u> | |
| | 9. Birthplace (State or Foreign Country) <u>Maryland</u> | | 10a. State <u>MD</u> | | 10b. County <u>N/A</u> | | 10c. City, Town or Location <u>Baltimore</u> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number <u>3022 Baker St.</u> | | 10f. Zip Code <u>21216</u> | | 10g. Citizen of What Country? <u>USA</u> | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>Black</u> | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>2</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Claims Examiner</u> | | 16b. Kind of Business/Industry <u>Social Security Adm.</u> | | | |
| | 17. Father's Name (First, Middle, Last) <u>Henry Stith</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Fannie Stith</u> | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) <u>Miss Christal Hanley (Grand Daughter)</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3022 Baker St. Baltimore, Md. 21216</u> | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Maryland National Cem.</u> | | 20c. Location - City or Town, State <u>8/21/99 Laurel Maryland</u> | | 21. Signature of Funeral Service Licensee <u>Joseph L. Russ</u> | |
| Physician /Medical Examiner | 22. Name and Address of Facility <u>Joseph L. Russ Funeral Home</u> <u>2222 W North Ave. Baltimore, Md. 21216</u> | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Septic shock</u> Due to (or as a consequence of): <u>Carcenoma Breast Metastatic</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Anemia</u> | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <u>[Signature]</u> | | 29c. License number <u>D55844</u> | |
| State Registrar | 29d. Date signed (Month, Day, Year) <u>8/18/99</u> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>M. Robinson</u> | | | | | |
| | 31. Date filed (Month, Day, Year) <u>AUG 24 1999</u> | | 32. Registrar's Signature <u>[Signature]</u> | | | | | |

ORIGINAL

Reg. No.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26607

| | | | | | | | | |
|--|---|---|--|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CHESTER NELSON SHERMAN | | | | 2. Date of Death Month August Day 17 Year 1999 | | 3. Time of Death 6:15 AM | |
| | 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 218-14-6868 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 74 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb. 22, 1925 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 3451 Keswick Road | | | | 10f. Zip Code 21211 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician Self-employed | | | 16b. Kind of Business/Industry Electrical | |
| 17. Father's Name (First, Middle, Last) William Daniel Sherman | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Berwager | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Carol Marks Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3451 Keswick Road, Baltimore, Maryland 21211 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial | | Date 8/20/99 | | 20c. Location - City or Town, State Cockeysville, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Urosepsis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death 2 days 2 days | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Dementia | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number Do054808 | | 29d. Date signed (Month, Day, Year) August 17, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. A. Baltus - Dorsey, 504 Realea Court East, Odenton, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AA10

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

99 26608

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|---|---|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Theresa D. Taylor | | | | 2. Date of Death Month Day Year August 22, 1999 | | | | 3. Time of Death 8:15 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number) St. Agnes Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 219-52-8308 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 50 Yrs. | | If Under 1 Year Months Days | | 8. Date of Birth (Month, Day, Year) NOV. 2, 1948 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| To Be Completed by Funeral Director | 10e. Street and Number 1529 Ramsay St. | | | | 10f. Zip Code 21223 | | | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer/Assembly | | 16b. Kind of Business/Industry Book Binding | | | | | | |
| | 17. Father's Name (First, Middle, Last) John W. Williams | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ruth E. White | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Carol Ann Baker - sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1529 Ramsay Street, Baltimore, Md. 21223 | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | 20c. Date 8/27/99 | | 20d. Location - City or Town, State Baltimore, Md. | | | | |
| | 21. Signature of Funeral Service Licensee <i>Louis L. Grant</i> | | | | 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Anoxic Encephalopathy Due to (or as a consequence of): 4 days b. Cardiac Arrest Due to (or as a consequence of): 4 days c. Pneumonia (Bilateral Upper Lobes) Due to (or as a consequence of): 5 days d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Th. J. Enelow</i> | | 29c. License number D0052540 | | 29d. Date signed (Month, Day, Year) August 23, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas J. Enelow, M.D., St. Agnes HealthCare, 900 Caton Ave., Baltimore, Md. 21229 | | | | 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature <i>Benita B. Sparks</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Name: Taylor, Theresa

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26609

| | | | | | | | |
|--|--|--|---|--|---|---|--------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Delma Mae Thompson | | | | 2. Date of Death Month Day Year August 20 1999 | | 3. Time of Death 2310 |
| | 4a. Facility Name (If not institution, give street and number) Fallston General Hospital | | | | 4b. City, Town, or Location of Death Fallston | | 4c. County of Death Harford |
| Funeral Director | 5. Social Security Number 222-03-2151 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | 8. Date of Birth (Month, Day, Year) April 12, 1915 | 9. Birthplace (State or Foreign Country) Delaware | | |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Baltimore | 10c. City, Town or Location Dundalk | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 6740 Danville Avenue | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? United States | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | |
| | 16b. Kind of Business/Industry Own Home | | 17. Father's Name (First, Middle, Last) Harry Dodd | | 18. Mother's Name (First, Middle, Maiden Surname) Arzie Pettijohn | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Mrs. Suzanne Rouch/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3213 Peverly Run Road Abingdon, MD 21009 | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park | | Date 8/24/99 | 20c. Location - City or Town, State Dorsey, Maryland | |
| | 21. Signature of Funeral Service Licensee Johnny L. Dade | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Ten years Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier Mark Wild | | 29c. License number d35522 | | 29d. Date signed (Month, Day, Year) August 20, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Wild 2 North Avenue Bel Air Maryland 21014 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature Kenne S. Sparks | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 92 26610

| | | | | | | | | |
|--|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Carolyn M. Tippet | | | | 2. Date of Death Month Day Year August 20, 1999 | | 3. Time of Death 12:30 PM | |
| | 4a. Facility Name (If not institution, give street and number) 5 Rognel Avenue | | | | 4b. City, Town, or Location of Death Catonsville | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 216-28-3095 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 67 Yrs. | | 8. Date of Birth (Month, Day, Year) FEB 25, 1932 | |
| | 9. Birthplace (State or Foreign Country) New York | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Catonsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 5 Rognel Avenue | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper | | 16b. Kind of Business/Industry Social Services | | | |
| | 17. Father's Name (First, Middle, Last) Sigmund K. Charewich | | | | 18. Mother's Name (First, Middle, Maiden Surname) Frances Krause | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Thomas Tippet/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Rognel Avenue Catonsville, MD 21228 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Memorial Gardens | | 20c. Location - City or Town, State Marriottsville, MD | | 20d. Date 8/25/99 | |
| | 21. Signature of Funeral Service Licensee Dawn E. McDonald | | 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Baltimore, MD 21228 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| Physician /Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier [Signature] | | | | 29c. License number D40850 | | 29d. Date signed (Month, Day, Year) August 20, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) YVONNE CRANFORD MD 900 CATON AVE BALTIMORE MD 21229 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature [Signature] | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

DHMH 16 Rev 6/95

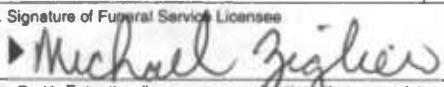
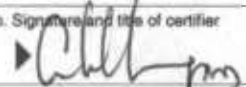
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26611

| | | | | | |
|---|---|---|---|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DORA WILLIAMS | | 2. Date of Death Month August Day 19 Year 1999 | | 3. Time of Death 11:41 AM |
| | 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 213-60-3361 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 56 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) 06-22-43 | | 9. Birthplace (State or Foreign Country) LOUISBURG, NC | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 5253 SAYBROOK RD | | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? U.S.A. |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. BLACK | | Specify: | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNKNOWN | | 16b. Kind of Business/Industry UNKNOWN |
| 17. Father's Name (First, Middle, Last) HURLEY WILLIAMS | | | 18. Mother's Name (First, Middle, Maiden Surname) IRENE WATT | | |
| 19a. Informant's Name/Relationship (Type, Print) CHARLENE WILLIAMS, DAUG. | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5253 SAYBROOK RD, BALTO. MD 21206 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MOUNT ZION | | Date 8-24-99 | 20c. Location - City or Town, State BALTIMORE, MD |
| 21. Signature of Funeral Service Licensee  | | | 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO, MD 21207 | | |
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) SEPSIS | | | | | |
| Due to (or as a consequence of): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | |
| Due to (or as a consequence of): | | | | | |
| Due to (or as a consequence of): | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier  MEDICINE HOUSESTAFF | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) AUGUST 19, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALAN CHENG, 600 WOLFE STREET, BALTIMORE, MARYLAND 21287 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26612

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PAROLEE J. WILLIAMS

2. Date of Death

Month

Day

Year

AUGUST

20

1999

3. Time of Death

3:19 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

MD

5. Social Security Number

240-40-8346

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

11/11/1930

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

521 Normandy Avenue

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Senior Aid

16b. Kind of Business/Industry

Clerical

17. Father's Name (First, Middle, Last)

Russell Jeter

18. Mother's Name (First, Middle, Maiden Surname)

Sadie Dawkins

19a. Informant's Name/Relationship (Type, Print)

Marie Lomax / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

521 Normandy Ave., Baltimore, Maryland 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park

Date

08/25/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility The Derrick C. Jones Funeral Hm.

4611 Park Heights Ave., Baltimore, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WEEK

b. LUNG CANCER

Due to (or as a consequence of):

6 MONTHS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

UTERINE CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

RESIDENT

29c. License number

P 12797

29d. Date signed (Month, Day, Year)

AUGUST 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHING M. GRAW

300, SOUTH HANOVER STREET

BALTIMORE MD 21225

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

| | | | | | | | | |
|--|---|--|--|--------------------------------|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CLARENCE EVERETTE WATERS, JR. III | | | | 2. Date of Death Month Day Year AUGUST 18 1999 | | 3. Time of Death 0022 | |
| | 4a. Facility Name (If not institution, give street and number) 1430 DRUID HILL AVE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 213 84 6197 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 37 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) OCT. 9, 1961 | | 9. Birthplace (State or Foreign Country) MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD. | 10b. County N/A | 10c. City, Town or Location BALTIMORE | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10a. Street and Number 1030 St. DUNSTANS ROAD | | | 10f. Zip Code 21212 | | 10g. Citizen of What Country? U.S. OF A. | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Year or Dates: 1979 1980 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (14 or 5+) UNKNOWN | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNEMPLOYED | | 16b. Kind of Business/Industry NONE | | | |
| | 17. Father's Name (First, Middle, Last) CLARENCE EDWARD WATERS, JR. FATHER | | | | 18. Mother's Name (First, Middle, Maiden Surname) NANCY HOWARD WATERS | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) CLARENCE E. WATERS, JR. (FATHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1030 ST. DUNSTANS ROAD BALTO., MD. 21212 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VET. CEM. | | 20c. Location - City or Town, State BALTO. OWINGS MILLS, MD. Co. | | | |
| | 21. Signature of Funeral Service Licensee <i>Lewis T. Gwynn</i> | | 22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVENUE BALTO., MD. | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Found: 8-18-99 | | 28b. Time of Injury Found: 12:16 | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: DWELLING | | 28d. Describe how injury occurred UNKNOWN | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1430 DRUID HILL AVE. BALTIMORE, MARYLAND | | | | | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier <i>Wynne Oneill</i> | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) AUGUST 18, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland N. Koppin MD - 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| | 31. Date (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26614

| | | | | | | | | | |
|--|---|---|---|--------------------------------------|---|--|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES P. WILLINGER | | | | 2. Date of Death Month Day Year AUG. 18, 1999 | | 3. Time of Death 6:28 P. | | |
| | 4a. Facility Name (If not institution, give street and number) 704 S. ROBINSON ST. | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 215-46-7255 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 51 Yrs. | | 8. Date of Birth Month Day Year MAY 17, 1948 | | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) MD. | | 10. State MD. | | 10b. County N/A | | |
| To Be Completed by Funeral Director | 10a. State MD. | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 704 S. ROBINSON ST. | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? U.S.A. | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DISABLED | | 16b. Kind of Business/Industry N/A | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) WILBUR WILLINGER | | | | 18. Mother's Name (First, Middle, Maiden Surname) ELEANORA BOWERS | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) ELEANORA WILLINGER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 S. ROBINSON ST. BALTO. MD. 21224 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) SAC. HEART OF JESUS | | 20c. Date CEM. AUG-20 1999 | | 20d. Location - City or Town, State BALTIMORE, MD. | | |
| | 21. Signature of Funeral Service Licensee Thomas J. Sparks Jr. | | 22. Name and Address of Facility SKARDA FH. 2829 HUDSON ST. BALTIMORE, MD. 21224 | | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Pancreatic Cancer | | Approximate Interval Between Onset and Death 5 MONTHS | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Michael Staff Physician | | 29c. License number D19714 | | 29d. Date signed (Month, Day, Year) 8/19/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL PURRI THURNE 4940 TEATON AVE BALTIMORE MD 21224 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 24 1999 | | 32. Registrar's Signature James B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State
Registrar

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Your obedient servant,

J. H. [Signature]

[Faint text, possibly a second paragraph or a note]

[Faint text, possibly a third paragraph or a note]

[Faint text, possibly a fourth paragraph or a note]

[Faint text, possibly a fifth paragraph or a note]

[Faint text, possibly a sixth paragraph or a note]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26615

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elbert Charles Wright

2. Date of Death

Month Day Year
August 21, 1999

3. Time of Death

3:39 P.M.

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

228-90-5393

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

43

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG 3, 1956

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

202 E. Lafayette Avenue

10f. Zip Code

21202

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: Black15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Tailor

16b. Kind of Business/Industry

Clothing

Manufacturing

17. Father's Name (First, Middle, Last)

Leroy Wright

18. Mother's Name (First, Middle, Maiden Surname)

Mary M. Perkins

19a. Informant's Name/Relationship (Type, Print)

Lela F. Whitley/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1309 Belvedere Ave. Baltimore, MD 21239

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory, Inc. 08/24/99

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Md., Inc.
299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Gunshot Wounds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending Investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

8-21-99

28b. Time of Injury

1517P M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

subject shot

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1800 Guilford Ave Baltimore, Md

29a. Certifier
(Check only one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dennis J. Chute

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute, Jr.

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

D. Sparks

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26616

Patient Known As: Geraldine Wooden
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Geraldine Wooden | | 2. Date of Death Month <u>August</u> Day <u>21</u> Year <u>1999</u> | | 3. Time of Death <u>10:00 AM</u> | |
| 4a. Facility Name (If not institution, give street and number) <u>Sinai Hospital of Baltimore</u> | | 4b. City, Town, or Location of Death <u>Baltimore City</u> | | 4c. County of Death <u>NA</u> | |
| 5. Social Security Number <u>214-56-3540</u> | | 6. Sex <u>1</u> M <u>2</u> F | | 7. Age (In yrs. last birthday) <u>49</u> Yrs. | |
| 8. Date of Birth (Month, Day, Year) <u>11-19-49</u> | | 9. Birthplace (State or Foreign Country) <u>MD</u> | | | |
| Usual Residence of Decedent | | 10a. State <u>MD</u> | | 10b. County <u>NA</u> | |
| 10c. City, Town or Location <u>Baltimore</u> | | 10d. Inside City Limits <u>XX</u> Yes <u>2</u> No | | | |
| 10e. Street and Number <u>2208 Whittier Avenue</u> | | 10f. Zip Code <u>21217</u> | | 10g. Citizen of What Country? <u>USA</u> | |
| 11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: <u>Black</u> | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th Grade</u> College (1-4 or 5+) <u>NA</u> | | 16. Kind of Business/Industry <u>Private Duty</u> | |
| 17. Father's Name (First, Middle, Last) <u>Payton Edmond</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Corrie Wooden</u> | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Linda L. Makle</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2208 Whittier Avenue Baltimore, Maryland 21217</u> | | | |
| 20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Arbutus Mem. Pk. Cem. 08-25-99 Arbutus, MD</u> | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee <u>[Signature]</u> | | 22. Name and Address of Facility <u>Baltimore, Maryland 21202</u> <u>WM.C. March FH 1101 E. North Avenue</u> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Acute Myocardial Infarction</u> Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>GI BLEED</u> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | Approximate Interval Between Onset and Death <u>5 days</u> | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>GI BLEED</u> | | 23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown | | 24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No | | 25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No | | 26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) | |
| 27. Manner of Death <u>1</u> Natural <u>5</u> Pending investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury <u>M</u> | |
| 28c. Injury at Work? <u>1</u> Yes <u>2</u> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29. Certifier (Check only) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29c. License number <u>A3240232 MM 29B</u> | |
| 29d. Date signed (Month, Day, Year) <u>August 21, 1999</u> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Michelle B. Mennette, M.D. Sinai Hospital of Baltimore</u> | | | |
| 31. Date filed (Month, Day, Year) <u>AUG 24 1999</u> | | 32. Registrar's Signature <u>[Signature]</u> | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26617

| | | | | | | | | | | |
|--|--|--|---|--|--|---------------------------------|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Robert Wilkerson</u> | | | | 2. Date of Death Month <u>August</u> Day <u>19</u> Year <u>1999</u> | | | | 3. Time of Death <u>1:08 PM</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>ST. JOSEPH MEDICAL CENTER</u> | | | | 4b. City, Town, or Location of Death <u>TOWSON</u> | | | | 4c. County of Death <u>BALTIMORE</u> | |
| Funeral Director | 5. Social Security Number <u>214-26-3726</u> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>70</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>DEC 9, 1928</u> | | 9. Birthplace (State or Foreign Country) <u>MD.</u> | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State <u>MD</u> | | 10b. County <u>BALTIMORE</u> | | 10c. City, Town or Location <u>PARKVILLE</u> | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number <u>2304 PUTTY HILL AVE</u> | | | | 10f. Zip Code <u>21234</u> | | | | 10g. Citizen of What Country? <u>U.S.A.</u> | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>ARMY / KOREA</u> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u> | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>INSURANCE CLAIMS</u> | | | | 16b. Kind of Business/Industry <u>EQUIFAX</u> | |
| | 17. Father's Name (First, Middle, Last) <u>CARROLL G. WILKERSON</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>LILIAN M. UBER</u> | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) <u>JOAN C. WILKERSON, SPOUSE</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2304 PUTTY HILL AVE PARKVILLE, MD. 21234</u> | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>MORELAND MEM. PARK</u> | | Date <u>AUG 24 1999</u> | | 20c. Location - City or Town, State <u>PARKVILLE, MD.</u> | |
| | 21. Signature of Funeral Service Licensee <u>Charles O'Donnell</u> | | | | 22. Name and Address of Facility <u>EVANS FUNERAL CHAPEL</u> | | | | 8800 HARFORD RD. PARKVILLE, MD. 21234 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death) a. <u>Cardiac Arrhythmia</u> Due to (or as a consequence of): b. <u>Arteriosclerotic Cardio</u> Due to (or as a consequence of): c. <u>Renal Vascular Disease</u> Due to (or as a consequence of): d. | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury <u>M</u> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of Certifier <u>Charles F. O'Donnell MD</u> | | | | 29c. License number <u>D-09383</u> | | | | 29d. Date signed (Month, Day, Year) <u>AUGUST 19, 1999</u> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Charles F. O'Donnell MD Baltimore MD 21210</u> | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>AUG 24 1999</u> | | | | 32. Registrar's Signature <u>B. Sparta</u> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

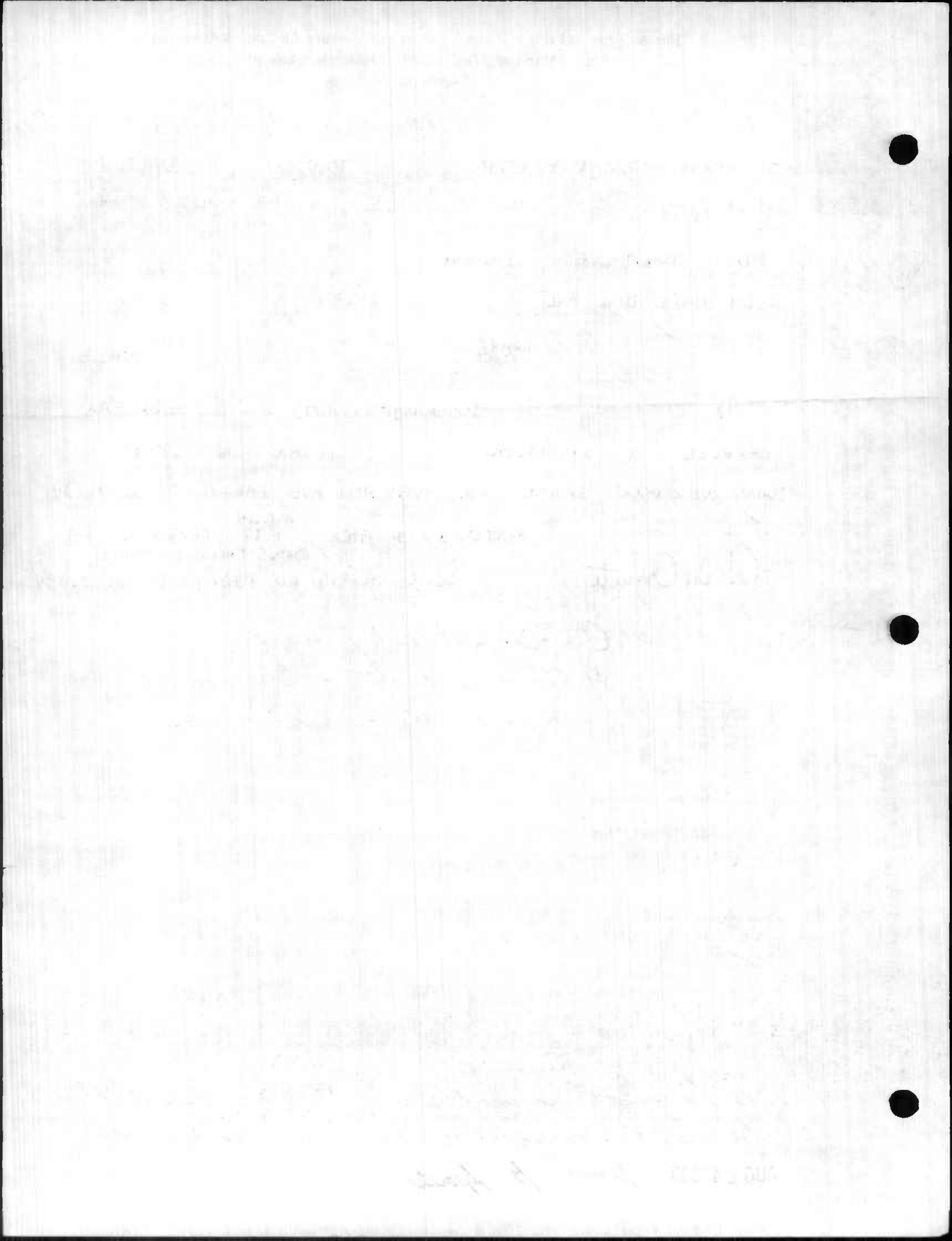
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26618

| | | | | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Eddie Wilson | | | | 2. Date of Death Month August Day 17 Year 1999 | | | | 3. Time of Death 145PM | | | |
| | 4a. Facility Name (If not institution, give street and number) Bayview Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | | | |
| Funeral Director | 5. Social Security Number 219-66-8520 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) 7 8 33 | | 9. Birthplace (State or Foreign Country) Virginia | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number 740 Poplar Grove St. APT 8J | | | | 10f. Zip Code 21216 | | | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CUSTODIAN | | | | 16b. Kind of Business/Industry Balto-Gas-Electric | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) John Wilson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Eula Goins Wilson | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mr. Moses W. Douglas | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1727 Chilton St. Baltimore, Md. 21218 | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. Zion Cem. | | Date 8/24/99 | | 20c. Location - City or Town, State Baltimore, Md. | | | | | |
| | 21. Signature of Funeral Service Licensee Joseph L. Russ | | | | 22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216 | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Arrest | | | | | | | | | | | |
| | Due to (or as a consequence of): Multiple Organism sepsis - VRE, MRSA | | | | | | | | | | | |
| | Due to (or as a consequence of): Acute Renal Failure | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | |
| | Due to (or as a consequence of): Chronic Heart Failure | | | | | | | | | | | |
| | Approximate Interval Between Onset and Death 7/min | | | | | | | | | | | |
| | Approximate Interval Between Onset and Death ~1 week | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Liver Failure, Congestive | | | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier Marta OWES | | | | 29c. License number RES-000 | | | | 29d. Date signed (Month, Day, Year) 8/18/99 | | | |
| | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Dr. Marta OWES, SUBMC, 4900 Eastern Ave, Baltimore, MD 21224 | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Handwritten signature and text: *Handwritten signature* FORT L. DUA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26619

| | | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Irma Worsham | | | | 2. Date of Death Month Day Year August 19, 1999 | | | | 3. Time of Death 8:10 PM | |
| | 4a. Facility Name (If not institution, give street and number) Villa St. Michael 4800 Seton Drive | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 213-28-3264 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 29, 1910 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | 10e. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10e. Street and Number 4800 Seton Drive | | | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own Home | |
| | 17. Father's Name (First, Middle, Last) John H. Worsham | | | | 18. Mother's Name (First, Middle, Maiden Surname) Cecelia Peetz | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Villa St. Michael | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 Seton Drive, Baltimore, Maryland 21215 | | | | | |
| | 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery | | 20c. Location - City or Town, State 8/24/99 Baltimore, Maryland | | | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Lynn B. Henss | | | | 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. END STAGE ALZHEIMER DEMENTIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. c. d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 6 MONTHS | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Deborah I. Pierce | | 29c. License number H45931 | |
| | 29d. Date signed (Month, Day, Year) August 23, 1999 | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deborah I. Pierce 1220 Park Heights Ave Balt. Md 21208 | | | | 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | 32. Registrar's Signature B. Sparks | |
| | State Registrar | | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26620

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Charles John Zaledonis
2. Date of Death Month Day Year August 20, 1999
3. Time of Death 8:45am

4a. Facility Name (If not institution, give street and number) VA MARYLAND HEALTH CARE SYSTEM
4b. City, Town, or Location of Death Fort Howard
4c. County of Death Baltimore

Funeral
Director

5. Social Security Number 189-03-7921
6. Sex 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday) 80 Yrs.
8. Date of Birth (Month, Day, Year) August 23, 1918
9. Birthplace (State or Foreign Country) Pennsylvania

Usual Residence of Decedent
10a. State Maryland
10b. County Baltimore
10c. City, Town or Location Dundalk
10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 2722 Plainfield Road
10f. Zip Code 21222
10g. Citizen of What Country? United States

11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Elementary/Secondary (0-12) 10 Years College (1-4 or 5+) Police Department Steel Industry

17. Father's Name (First, Middle, Last) John Zaledonis
18. Mother's Name (First, Middle, Maiden Surname) Celia Not Known

19a. Informant's Name/Relationship (Type, Print) Genevieve Zaledonis/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2722 Plainfield Road Dundalk, Maryland 21222

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem. 8/24/1999
20c. Location - City or Town, State Rosedale, Maryland

21. Signature of Funeral Service Licensee
22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) a. Sub Acute Bacterial Endocarditis
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary Heart Disease
Congestive Heart Failure
Aortic Valve Prosthesis, Old Stroke
Diabetis Mellitus

23c. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Aurora C. Tan, M.D.
29c. License number D14958
29d. Date signed (Month, Day, Year) August 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aurora C. Tan, M.D. VA MARYLAND HEALTH CARE SYSTEM FORT HOWARD

31. Date filed (Month, Day, Year) AUG 24 1999
32. Registrar's Signature

State
Registrar

ZALEDONIS, Charles John
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMEND ITEMS: #27, 28A-F PER MEO G774 8-24-99 WR.

Reg. No. 99 26621

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Melvin R. Barrick

2. Date of Death

Month
JulyDay
3rdYear
1999

3. Time of Death

2:15pm

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

Carroll County Gen. Hosp

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

216-07-4396

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Aug. 22, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

543 Spruce Avenue

10f. Zip Code

21157

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: W.W. II13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Congoleum Corporation

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Winnie Barrick

19a. Informant's Name/Relationship (Type, Print)

Gretchen Barrick/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

543 Spruce Avenue, Westminster, MD 21157

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Van Sant

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Pneumonia

Approximate
Interval Between
Onset and Death

Two weeks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Obstructive Esophagus from Foreign body

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease,
atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)

6-12-99

28b. Time of
Injury

UNKNOWN

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

CHOKED ON BOLUS OF FOOD

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)
HOME28f. Location (Street and Number or Rural Route Number,
City or Town, State)

543 SPRUCE AVE, WESTMINSTER MD.

29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Van Sant, MD

29c. License number

D48006

29d. Date signed (Month, Day, Year)

July 3rd 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KORI BOATEY, 200 Memorial Ave, Westminster, MD 21157

State
Registrar

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

Laura B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

99-4918-510

B.K.S

HAZEL BELL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26622

| | | | | | | | | |
|--|---|---|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Hazel Bell | | | | 2. Date of Death Month Day Year AUG. 20, 1999 | | 3. Time of Death 10:58 AM | |
| | 4a. Facility Name (If not institution, give street and number) 11 WEST 20TH STREET APT.#2-R | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 216-42-5728 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) 06 08 33 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) V.A. | | 10. State MD | | 10b. County NA | |
| To Be Completed by Funeral Director | 10a. State | | 10b. County | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 11 West 20th Street Apt #2-R | | | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) na | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Processor | | 16b. Kind of Business/Industry Gordan Color Lab | | | |
| | 17. Father's Name (First, Middle, Last) Richard Corbin | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sadie Thompson | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Linda Berry-Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3414 Ludgate Road, Baltimore Md 21215 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | 20c. Date 8/26/99 | | 20d. Location - City or Town, State Randallstown, Md | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? INSPECTION 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) AUG. 20, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26623

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CHARLOTTE BARNWELL | | | | 2. Date of Death Month August Day 16 Year 1999 | | 3. Time of Death 12.27 AM | |
| | 4a. Facility Name (If not institution, give street and number) Northwest Medical Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 137-28-8995 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 67 Yrs. | | 8. Date of Birth (Month, Day, Year) 12 10 31 | |
| | 9. Birthplace (State or Foreign Country) South Carolina | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 3802 Cassandra Rd | | 10f. Zip Code 21133 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse | | | | 16b. Kind of Business/Industry Private Hospital | | 17. Father's Name (First, Middle, Last) Dave platt | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname) Emily Houston | | | | 19a. Informant's Name/Relationship (Type, Print) Mrs Linda Barnwell (Daughter-in-law) | | | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Candlewood ct. Randallstown, Md. 21207 | | | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery | | | | 20c. Location - City or Town, State Baltimore Md. | | | |
| | 21. Signature of Funeral Service Licensee Joseph L. Russ | | | | 22. Name and Address of Facility Joseph L. Russ Funeral Home 2322 W. North Ave. Balto. Md. 21216 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. congestion Heart failure Due to (or as a consequence of): coronary artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diabetic Mellitus Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 1 day 5 yr | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetic Mellitus | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) 8/18/99 | | | |
| | 28b. Time of Injury M | | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier M. R. ... | | | | 29c. License number D25044 | | | |
| | 29d. Date signed (Month, Day, Year) 8/18/99 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. R. ... 2717 Hammonds Ferry Rd 21227 | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 25 1999 | | | | 32. Registrar's Signature James B. Sparks | | | |

DAVON BLUE
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#16a perFH G774 8/25/99 EW

Certificate of Death

Reg. No.

99 26624

| | | | | | | | | |
|--|---|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DAVON JEROME BLUE | | | | 2. Date of Death Month Day Year AUGUST 18 1999 | | 3. Time of Death 3:01 A | |
| | 4a. Facility Name (If not institution, give street and number) BAYVIEW HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 219-82-8813 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 24 Yrs. | | 8. Date of Birth (Month, Day, Year) DEC. 12, 1974 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9TH GRADE College (1-4 or 5+) Never Worked | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER | | 16b. Kind of Business/Industry N/A | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 17. Father's Name (First, Middle, Last) WILBERT BLUE | | | | 18. Mother's Name (First, Middle, Maiden Surname) BERTHA STACKER | | | | |
| 19a. Informant's Name/Relationship (Type, Print) BERTHA JONES (MOTHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2882 HWY 210 NORTH LOT 21, SPRING LAKE, NC 28390 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY | | 20c. Date 8-25-99 | | 20d. Location - City or Town, State LANSDOWNE, MARYLAND | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVENUE, BALTIMORE MD 21217 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound of Back of Torso Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 8/18/99 | | 28b. Time of Injury 1:50 A M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred subject was shot | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5500 Bk Bowleys Lane Baltimore, Md | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) AUGUST 18, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#19b perFH G774 8/25/99 EW

Certificate of Death

Reg. No.

99 26625

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) REBECCA BROWN | | | | 2. Date of Death Month Day Year AUGUST 19, 1999 | | 3. Time of Death 8:30 AM | |
| | 4a. Facility Name (If not Institution, give street and number) 207 NORTH AMITY STREET | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death NIA | |
| Funeral Director | 5. Social Security Number 244-46-7012 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) FEB. 27, 1921 | |
| | 9. Birthplace (State or Foreign Country) NORTH CAROLINA | | 10a. State MARYLAND | | 10b. County NIA | | 10c. City, Town or Location BALTIMORE CITY | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 207 NORTH AMITY STREET | | 10f. Zip Code 21223 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | |
| | 17. Father's Name (First, Middle, Last) BRUCE EDWARDS | | | | 18. Mother's Name (First, Middle, Maiden Surname) EASTER GRIM | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) RENO DAVIS (GRANDSON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 585 WALNUT AVENUE, LONG BEACH CA. 90802 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY | | 20c. Location - City or Town, State 8-26-99 LANSDOWNE, MARYLAND | | 21. Signature of Funeral Service Licensee JOSEPH H. BROWN JR. FUNERAL HOME | |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility 2140 N. FULTON AVE. BALTIMORE MD 21217 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atherosclerotic Cardiovascular Disease | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Breast Carcinoma | | | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier [Signature] | | 29c. License number D32158 | | 29d. Date signed (Month, Day, Year) 8/23/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jyoti Parikh MD 821 N. Eutaw Street, Suite 407, Baltimore, MD 21201 | |
| | 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature [Signature] | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26626

| | | | | | |
|---|---|--|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BERTHA BRISKMAN | | 2. Date of Death Month Day Year AUGUST 23, 1999 | | 3. Time of Death 3:00 PM |
| | 4a. Facility Name (If not institution, give street and number) LEVINDALE HEBREW HOME | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 083-42-4619 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) SEPT. 8, 1920 |
| | 9. Birthplace (State or Foreign Country) VIENNA, AUSTRIA | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State MD | 10b. County BALTIMORE | 10c. City, Town or Location PIKESVILLE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 413 YESHIVA LANE | | 10f. Zip Code 21208 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | | |
| | 17. Father's Name (First, Middle, Last) DAVID RABINOWITZ | | 18. Mother's Name (First, Middle, Maiden Surname) ESTHER (UNKNOWN) | | |
| | 19a. Informant's Name/Relationship (Type, Print) NACHUM LANSKY / NEPHEW | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 YESHIVA LANE - PIKESVILLE, MD 21208 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) HAR HAZAISIM CEMETERY | | 20c. Location - City or Town, State 8/25/99 JERUSALEM, ISRAEL |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) ACUTE CARDIAC ARREST Due to (or as a consequence of): | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last CORONARY ARTERY DISEASE Due to (or as a consequence of): | | | | |
| | VENTILATOR DEPENDENT Due to (or as a consequence of): | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. TRANSECTION OF SPINAL CORD C1-C2 | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M |
| | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier | | 29c. License number 0:44907 | | 29d. Date signed (Month, Day, Year) August 24th 1999 |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 2434 W. Edwinton Ave Baltimore, MD 21215 | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25627

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BETTY JEAN BECKER

2. Date of Death

August 21 1999 9:00 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

BALTIMORE

5. Social Security Number

218-32-8360

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 13, 1937

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Md.10b. County
Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1127 Chester Road

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Bank Administrator

16b. Kind of Business/Industry

First Union

17. Father's Name (First, Middle, Last)

Harry Chester Sigler

18. Mother's Name (First, Middle, Maiden Summa)

Audre LePole

19a. Informant's Name/Relationship (Type, Print)

Ruth Merritt / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3726 D White Pine Road Baltimore Md. 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Holly Hill Cemetery 8/25/99

Date

20c. Location - City or Town, State

Baltimore Md.

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex
300 MACE AVE. Baltimore Md. 2122123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 Week

6 Months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

Respiratory Failure

Gangrenous Colon

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

J. M. Sparks

29c. License number

J52340

29d. Date signed (Month, Day, Year)

8/21/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IYAN ROSAS, MD 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MARYLAND 21237

State
Registrar

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

J. M. Sparks

ORIGINAL

BECKER, BETTY J

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

A410

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26628

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James McDonald Baker

2. Date of Death

Month Day Year

Aug.

21

1999

3. Time of Death

3:30 PM

4a. Facility Name (If not Institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

246-60-8516

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)

Sept. 12, 1941

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

131 Timberbrook Lane #203

10f. Zip Code

20878

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

English Teacher

16b. Kind of Business/Industry

Montgomery County
School System

17. Father's Name (First, Middle, Last)

Joseph Mack Baker

18. Mother's Name (First, Middle, Maiden Surname)

Ann Carolyn (Dove)

19a. Informant's Name/Relationship (Type, Print)

Rosalie A. Baker (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

131 Timberbrook Lane, Gaithersburg, MD 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Balt./Wash. Crematory

Date

Aug.

24, 1999

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Homes, Inc.
5555 Twin Knolls Rd. Columbia, MD 2104523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

1 HOUR

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. MASSIVE PONTINE INFARCT

Due to (or as a consequence of):

6 DAYS

c. BASILAR ARTERY THROMBOSIS

Due to (or as a consequence of):

6 DAYS

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D26344

29d. Date signed (Month, Day, Year)

08/21/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOLY CROSS HOSPITAL SILVER SPRING

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26629

| | | | | | | | | |
|--|---|---------------------------|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Dorothy Cunningham | | | | 2. Date of Death Month 8 Day 20 Year 99 | | 3. Time of Death 9:55 PM | |
| | 4a. Facility Name (If not institution, give street and number) Mercy Medical | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 220-64-2335 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec. 27, 1927 | |
| | Usual Residence of Decedent | | | | | | 9. Birthplace (State or Foreign Country) New York | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County N/A | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 3313 Mayfair Rd. | | | 10f. Zip Code 21207 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Negro | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Frank Howard | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Smith | | | |
| | 19a. Informant's Name/Relationship (Type, Print) (Son) Rev. Johnny Carrington Sr. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3313 Mayfair Rd. Balto. Md. 21207 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion | | 20c. Location - City or Town, State 8/28/99 Lansdowne, Md. | | | |
| | 21. Signature of Funeral Service Licensee Joseph L. Russ | | 22. Name and Address of Facility Joseph L. Russ Funeral Home 2224 W. North Ave. Balto. Md. 21216 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. S. pneumonia Due to (or as a consequence of): b. Staphylococcal sepsis Due to (or as a consequence of): c. Renal Insufficiency Due to (or as a consequence of): d. Hypertensive Cardiovascular disease | | | | | | | Approximate Interval Between Onset and Death 6 wks 6 wks. 2 yrs. 7 yrs. |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gangrene Left Leg & Right Foot | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | |
| | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| State Registrar | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier Louis E. Grenier | | | | 29c. License number 001442 | | 29d. Date signed (Month, Day, Year) 8/21/99 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Louis E. Grenier 3015 T.O. Pl. #815 B. 1 to md 21202 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 25 1999 | | Registrar's Signature Bryan B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AH2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26630

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James J. Cuffie

2. Date of Death

August 23, 1999 12:30am

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Lorien Frankford Nursing + Rehab. Ctn. Baltimore

4b. City, Town, or Location of Death

4c. County of Death

NA

5. Social Security Number

246-07-2890

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
09 15 21

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5009 Frankford Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

2yrs.

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Graphic Arts

16b. Kind of Business/Industry

Dept. of Army

17. Father's Name (First, Middle, Last)

Edward Cuffie

18. Mother's Name (First, Middle, Maiden Surname)

Stella Cuffie

19a. Informant's Name/Relationship (Type, Print)

Ronald Cuffie

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1017 Loch Raven Blvd. Baltimore, MD. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Baltimore Nat'l Cem. 08-26-99 Baltimore, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

B. Bernard Johnson

22. Name and Address of Facility

Baltimore, Maryland 21202
WM.C., March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ADVANCED ALZHEIMERS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7RS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CACHEXIA; DYSRHYTHMIA; SEIZURES

DISORDER; TYPE II DM; HTN; ASCVD;

CVA & DYSPNOEA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Bernard Johnson

29c. License number

D41291

29d. Date signed (Month, Day, Year)

8/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Cuffie, MD. 21 CROSSROADS DR. #330

GWING MILLS, MD 21117

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

B. Bernard Johnson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26631
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANITA JOYCE CUMMINS

2. Date of Death
Month Day Year
August 23 1999 5:29am

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number
213-52-0699

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)
63 Yrs.

8. Date of Birth (Month, Day, Year)
March 22, 1936

9. Birthplace (State or Foreign Country)
North Carolina

Usual Residence of Decedent

10a. State
Md.

10b. County
Baltimore

10c. City, Town or Location
Middle River

10d. Inside City Limits
1 ☐ Yes 2 ☒ No

10e. Street and Number
2215 Firethorn Road

10f. Zip Code
21220

10g. Citizen of What Country?
USA

11. Marital Status
1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker

16b. Kind of Business/Industry
own home

17. Father's Name (First, Middle, Last)
Ethridge G. Dixon

18. Mother's Name (First, Middle, Maiden Surname)
Irene Guthrie

19a. Informant's Name/Relationship (Type, Print)
Blair E. Cummins/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2215 Firethorn Road Baltimore Md. 21220

20a. Method of Disposition
☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Cemetery 8/25/99

20c. Location - City or Town, State
Baltimore Md.

21. Signature of Funeral Service Licensee
R. Terry Connolly

22. Name and Address of Facility
Connolly Funeral Home of Essex
300 Mace Ave. Baltimore Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspergillus Emphyema

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Lung Cancer

1 year

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease
Hypertension, Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death?
1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury
M

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier
Cherie Young, MD

29c. License number
RD 196691

29d. Date signed (Month, Day, Year)
August 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Cherie Young 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)
AUG 25 1999

32. Registrar's Signature
B. Sparks

State
Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 39 26632

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary Dingle | | | | 2. Date of Death Month Day Year Aug 21 1999 | | 3. Time of Death 2:10 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) Saint Agnes Hospital 900 Caton Ave | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 214-22-5992 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 04 10 27 | 9. Birthplace (State or Foreign Country) M.D. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 312 North Monastery Ave | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10th grade na | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Day Care Provider | | 16b. Kind of Business/Industry Private Home | | |
| 17. Father's Name (First, Middle, Last) Luther James Darden | | | | 18. Mother's Name (First, Middle, Maiden Surname) Addie Ashes | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Elijah Dingle-Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 N. Monastery Ave, Baltimore Md 21229 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | 20c. Location - City or Town, State 8/26/99 Randallstown, Md | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hepatocellular Carcinoma Due to (or as a consequence of): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 3 Months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Resident | | | | 29c. License number P12597 | | 29d. Date signed (Month, Day, Year) Aug, 21, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Ave Saint Agnes | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: Mary Dingle

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26633

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|---|--|---|---|---|--|---------|----------------------------------|--|----|----------------------------------|----|----------------------------------|----|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BENNIE DIXON | | | | 2. Date of Death Month AUG Day 20 Year 1999 | | 3. Time of Death 11:00 PM | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 2602 W. PATAPSCO AVE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 248-36-3076 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) DEC. 24, 1927 | 9. Birthplace (State or Foreign Country) SOUTH CAROLINA | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | 10b. County N/A | 10c. City, Town or Location BALTIMORE CITY | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | |
| | 10e. Street and Number 2602 W. PATAPSCO AVENUE | | | 10f. Zip Code 21230 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 10-12-50 11-21-56 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6TH GRADE College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER | | 16b. Kind of Business/Industry W. T. BENNETT & CO. | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) BUCK | | | | 18. Mother's Name (First, Middle, Maiden Surname) SIMMS MARYBELLE DIXON | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) PALACE DIXON (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2602 W. PATAPSCO APT. 2B BALD. MD. 21230 | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST CEME. 8-26-99 OWINGS MILLS, MD. | | 20c. Location - City or Town, State | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIMORE, MD. 21217 | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a. METASTATIC PANCREATIC ADENOCARCINOMA</td> <td>4 WEEKS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="2"></td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. METASTATIC PANCREATIC ADENOCARCINOMA | 4 WEEKS | Due to (or as a consequence of): | | b. | Due to (or as a consequence of): | c. | Due to (or as a consequence of): | d. | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. METASTATIC PANCREATIC ADENOCARCINOMA | 4 WEEKS | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | |
| | b. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| | c. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D50500 | | 29d. Date signed (Month, Day, Year) AUG 25, 1999 | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) FREDERICK B. KOTLER 10 N. GREENE STREET BALTIMORE MD 21201 | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

[Handwritten signature or initials in the center of the page.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26634

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY Donnelly

2. Date of Death

Aug 23 1999 3:15 PM

4e. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

158-20-7983

6. Sex

1 ☐ M 2 ☒ F

Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAR 3, 1928

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

22 S. Athol Avenue

10f. Zip Code

21229

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FILE CLERK

16b. Kind of Business/Industry

Unknown

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Sheila Williams

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22 S. Athol Avenue Baltimore, Md. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Sharon Adams Jones

22. Name and Address of Facility

MARSHALL UNIVERSITY, JR. F.H. 4401 Edmondson Avenue Balt. Md. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

< 1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. G.I. Bleeding

Due to (or as a consequence of):

1 day

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure disorder, Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

B. Lee

29c. License number

DS2544

29d. Date signed (Month, Day, Year)

AUG 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benjamin S. Lee, M.D. 500 N. Rolling Road, Suite 4, Catonsville, MD 21228

31. Date filed (Month, Day, Year)

AUG 24 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

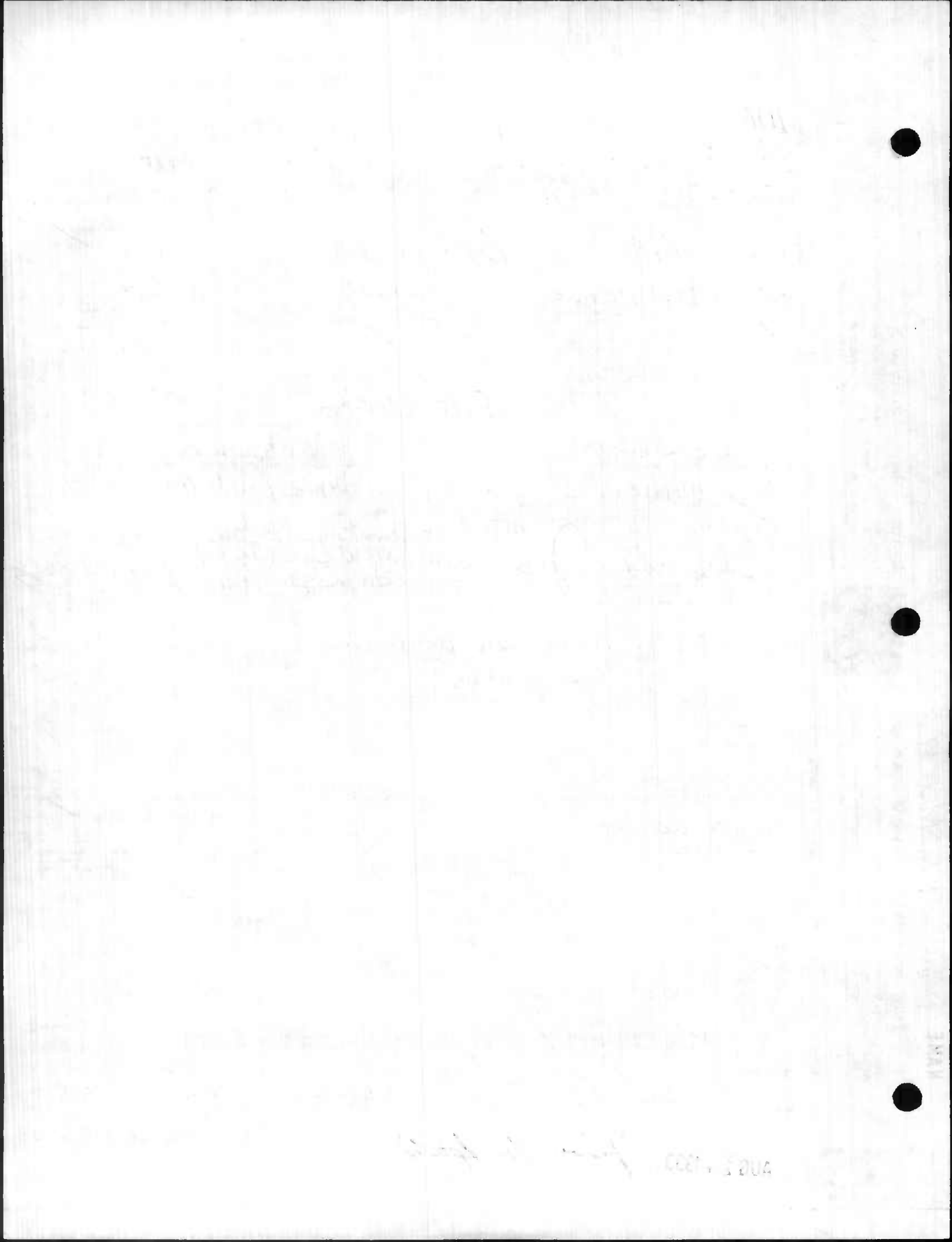
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

NAME Donnelly, Mary
Division of Vital Records, P.O. Box 68760,To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.State
Registrar

ORIGINAL



CONFIDENTIAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26635

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician
/Medical
ExaminerFuneral
DirectorPhysician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|---|
| 1. Decedent's Name (First, Middle, Last) Stephanie D. Dorsey | | 2. Date of Death Month August Day 24 Year 1999 | | 3. Time of Death 11:15 Am | |
| 4a. Facility Name (If not institution, give street and number) 1607 Mulberry Street | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | |
| 5. Social Security Number 213-88-0189 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 37 Yrs. | 8. Date of Birth Month August Day 22 Year 1962 | 9. Birthplace (State or Foreign Country) MD |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1607 Mulberry Street | | 10f. Zip Code 21223 | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: African American | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) 2 | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian | | 16b. Kind of Business/Industry Office Building | | 17. Father's Name (First, Middle, Last) Stanley Dorsey | |
| 18. Mother's Name (First, Middle, Maiden Surname) Brenda Dorsey | | 19a. Informant's Name/Relationship (Type, Print) Stanley Dorsey father | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1607 Mulberry St. Baltimore, MD 21223 | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill | | 20c. Location - City or Town, State 8/26/99 Glen Burnie, MD | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Albert P. Wilie Funeral Home PA 438 W. Guilford St. Baltimore, MD 21217 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIOPULMONARY ARREST Due to (or as a consequence of): b. MYOCARDIAL INFARCTION Due to (or as a consequence of): c. END STAGE RENAL DISEASE Due to (or as a consequence of): d. ACQUIRED IMMUNODEFICIENCY SYNDROME | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D46529 | |
| 29d. Date signed (Month, Day, Year) 8-25-1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VICTOR ONYEJIKA 2000 WEST BALTIMORE STREET BALTIMORE MARYLAND | | 31. Date filed (Month, Day, Year) AUG 25 1999 | |
| 32. Registrar's Signature | | 33. Registrar's Title B. Sparks | | 34. Registrar's Office Baltimore, MD | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26636

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

George Erhart

2. Date of Death

August 21 1999

3. Time of Death

2:40 AM

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

5. Social Security Number

154-09-3330

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

February 22, 1912

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6116 Belair Road

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4or 5+)

NA

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Auto Mechanic

16b. Kind of Business/Industry

Auto Repair Shop

17. Father's Name (First, Middle, Last)

UNK

18. Mother's Name (First, Middle, Maiden Surname)

UNK

19a. Informant's Name/Relationship (Type, Print)

Wanda Blackwell-Guardian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

34 Market Place BALTIMORE MD 21202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MOT. ZION

Date

8-24-99

20c. Location - City or Town, State

Crowsnest MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

ALBERT R. WYLLIE F/H PA

638 N. Gilman Street BALTIMORE MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 DAY

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

3 DAYS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STROKE

MUCOUS PLUGGING

ARTRIOVENTRICULAR CONDUCTION DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D15135

29d. Date signed (Month, Day, Year)

AUGUST 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DENISE P. SCOTT MD 561 WEST RIVER BLVD BALTIMORE, MD 21234

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Division of Vital Records, P.O. Box 68760,

MILATE

AH 3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26637

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Emil S. Ei

2. Date of Death

August 24 1999

3. Time of Death

4:00 AM

4a. Facility Name (If not institution, give street and number)

7146 Martell Ave

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

5. Social Security Number

215-12-5943

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

8. Data of Birth

April 9, 1919

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

7146 Martell Ave

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Wire Drawer

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

Ferdinand Ei

18. Mother's Name (First, Middle, Maiden Surname)

Valerie Broskaa

19a. Informant's Name/Relationship (Type, Print)

Alice Ei /wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7146 Martell Ave Baltimore, MD 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Christ Lutheran Cem.

Date

Aug 27

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Anthony C. Connelly

22. Name and Address of Facility

Connelly Funeral Home of Dundalk
7110 Sollers Point Rd 21222

23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic colon cancer to the liver

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 1/2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Larry Waterbury, M.D.

29c. License number

DO 9559

29d. Date signed (Month, Day, Year)

8/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LARRY WATERBURY, MD, JNHC 4940 Eastern Ave., Balt., Md. 21210

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26638

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Norman Ford

2. Date of Death
Month Day Year

08 22 99

3. Time of Death

11:00am

4a. Facility Name (If not institution, give street and number)

3600 Plateau Ave

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

220125918

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12 06 26

9. Birthplace (State or Foreign Country)

M.D.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3600 Plateau Ave

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Black

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7th grade

na

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

Blue Chip Product

17. Father's Name (First, Middle, Last)

Charles R. Ford Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Blanche B. Brown

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Ford-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3600 Plateau Ave, Baltimore Md 21207

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Garrison Forest Vet

Date

8/26/99 Owings Mills, Md

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Shannon Stokes

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore Md 21215

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

3 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Tao-Ping Chow MD

29c. License number

D34851

29d. Date signed (Month, Day, Year)

Aug 23, 1999

30. Name and address of person who completed Cause of death (Item 23a) (Type, Print)

2435 W. Belvidere Ave #220 Balto, MD 21215

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature and date: 1991 8 2 DUA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26639

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY

FREEDLANDER

2. Date of Death
Month Day Year
AUGUST 22, 19993. Time of Death
3:45PM

4a. Facility Name (If not institution, give street and number)

JEWISH CONVALESCENT HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

216-36-7655

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
OCT. 23, 1909

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4001 CLARKS LANE #211

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

DAVID

KANTER

18. Mother's Name (First, Middle, Maiden Surname)

RACHEL

BERKOWITZ

19a. Informant's Name/Relationship (Type, Print)

DAVID FREEDLANDER / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2400 BARE ROAD - BALTIMORE, MD 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HAR ZION TIFERETH ISRAEL

Date

8/24/99

20c. Location - City or Town, State

ROSEDALE, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Approximate Interval Between Onset and Death

IMMEDIATE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D15140

29d. Date signed (Month, Day, Year)

AUGUST 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IAN SUNSHINE, MD

6210 PK HTS Ave, BALT, MD 21215

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

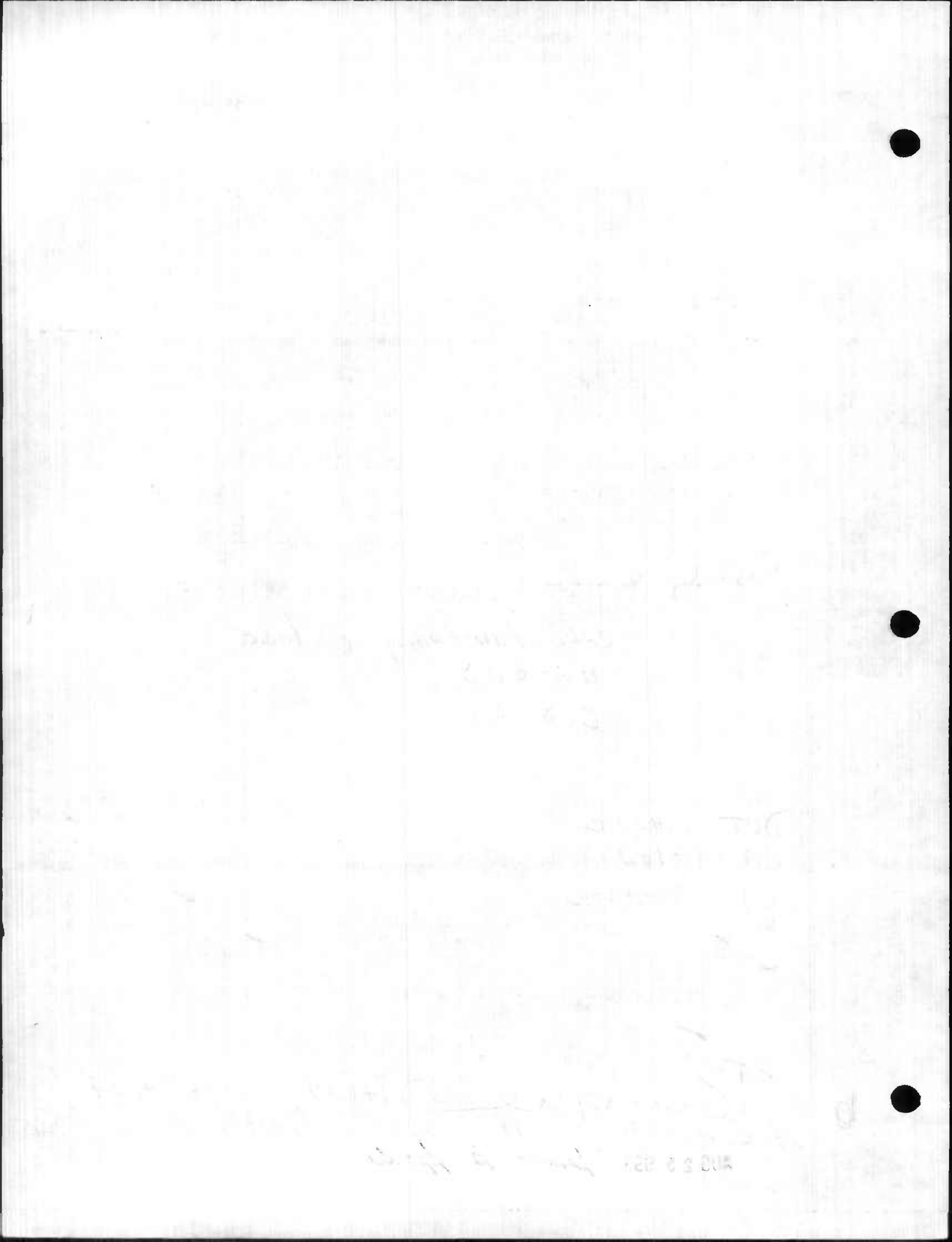
State of Maryland / Department of Health and Mental Hygiene 99 26640

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Richard Goodwin. Sr. | | | | 2. Date of Death Month Day Year August 23 1999 | | 3. Time of Death 8:45 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) 2805 Presstman Street | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 247-03-8422 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) 4-4-1913 | |
| | 9. Birthplace (State or Foreign Country) S.C. | | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2805 Presstman Street | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8th grade na | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Crane Operator | | 16b. Kind of Business/Industry Allied Chemical Corp | | | |
| | 17. Father's Name (First, Middle, Last) Rev. Willie Goodwin | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rev. Suzie Woler | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Richard Goodwin Jr.-Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2805 Presstman St. Baltimore Md 21216 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery | | 20c. Date 8/27/99 | | 20d. Location - City or Town, State Baltimore Co. Md | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee B. Lady Wamer | | 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIO PULMONARY FAILURE Due to (or as a consequence of): b. HASEUD Due to (or as a consequence of): c. OLD AGE Due to (or as a consequence of): d. { | | | | | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DVT CHRONIC CA Colon CA Prostate | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| State Registrar | 28d. Describe how Injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier A. C. Enrique MD | | 29c. License number D14829 | | 29d. Date signed (Month, Day, Year) 08/24/99 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. C. Enrique MD 2435 W. BELVEDERE AVE. 21215 | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature B. Spokes | | | | | |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26641

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Alice, Harrington</u> | | | | 2. Date of Death Month <u>August</u> Day <u>21</u> Year <u>1999</u> | | 3. Time of Death <u>0200</u> | |
| | 4a. Facility Name (If not Institution, give street and number) <u>Sinai Hospital 2401 W. Belvedere</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>N/A</u> | |
| Funeral Director | 5. Social Security Number <u>217-28-5192</u> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>73</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>DEC. 12, 1925</u> | |
| | 9. Birthplace (State or Foreign Country) <u>MARYLAND</u> | | 10a. State <u>MARYLAND</u> | | 10b. County <u>N/A</u> | | 10c. City, Town or Location <u>BALTIMORE CITY</u> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number <u>5319 WESLEY AVENUE</u> | | 10f. Zip Code <u>21207</u> | | 10g. Citizen of What Country? <u>USA.</u> | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u> | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12+HIGHER</u> College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>JANITORIAL WORK</u> | | 16b. Kind of Business/Industry <u>SELF-EMPLOYED</u> | | | |
| | 17. Father's Name (First, Middle, Last) <u>WILLIAM</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>SIMMS ALICE (MAY-UNKNOWN)</u> | | | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) <u>ULYSSES HARRINGTON (HUSBAND)</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5319 WESLEY AVENUE, BALTIMORE, MD. 21207</u> | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>DRUID RIDGE CEMETERY</u> | | 20c. Location - City or Town, State <u>BALTIMORE, MARYLAND</u> | | 20d. Date <u>8-28-99</u> | |
| Physician /Medical Examiner | 21. Signature of Funeral Service Licensee <u>[Signature]</u> | | 22. Name and Address of Facility <u>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217</u> | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Metastatic Lung Cancer</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>b.</u> Due to (or as a consequence of): <u>c.</u> Due to (or as a consequence of): <u>d.</u> | | Approximate Interval Between Onset and Death | | | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and Title of certifier <u>[Signature] MCGADD</u> | | 29c. License number <u>RES 000</u> | | 29d. Date signed (Month, Day, Year) <u>August 21/1999</u> | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>SINAI HOSPITAL, 2401 W. BELVEDERE, BALTIMORE, MD. 21215</u> | | | | | | 31. Date filed (Month, Day, Year) <u>AUG 25 1999</u> | |
| | 32. Registrar's Signature <u>[Signature] B. Sparks</u> | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26642

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN B HATLEY

2. Date of Death

Month Day Year
AUGUST 21 1999

3. Time of Death

3:30am

4a. Facility Name (If not institution, give street and number)

1200 Magness Court

4b. City, Town, or Location of Death

Belcamp

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

242-26-2555

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 13 1926

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Md

10b. County

Harford

10c. City, Town or Location

Belcamp

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1200 Magness Court

10f. Zip Code

21017

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Marvin A Brown

18. Mother's Name (First, Middle, Maiden Surname)

Anna Duncan

19a. Informant's Name/Relationship (Type, Print)

Deborah McFadden / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1200 Magness Court BelCamp Md. 21017

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dulaney Valley Cemetery 8/24/99

Date

20c. Location - City or Town, State

Baltimore Md.

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex

300 Mace Ave. Baltimore Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardio-respiratory arrest

Due to (or as a consequence of):

Approximate interval Between Onset and Death

2 hrs

b. Metastatic Peritoneal Cancer

Due to (or as a consequence of):

1 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☒ Residence☐ Nursing Home ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. F. Silver

29c. License number

D0045793

29d. Date signed (Month, Day, Year)

8/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David F. Silver, MD 2411 W Belvedere Ave Balto, MD 21215

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26613

| | | | | | | | | |
|---|---|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES HUNTZBERRY | | | | 2. Date of Death Month Day Year AUGUST 20 1999 | | 3. Time of Death 3-40 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 212-58-8211 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 48 Yrs. | | 8. Date of Birth (Month, Day, Year) June 27, 1951 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Md. | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3623 Leo Street | | 10f. Zip Code 21226 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tow Truck Driver | | 16b. Kind of Business/Industry Self Employed | | | | |
| 17. Father's Name (First, Middle, Last) Edward T. Huntzberry | | | | 18. Mother's Name (First, Middle, Maiden Surname) Bertha Mae Herberson | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Sandra Huntzberry (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3623 Leo Street Baltimore, Maryland 21226 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park | | 20c. Date 8/24/99 | | 20d. Location - City or Town, State Glen Burnie, Maryland | | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; align-items: flex-start;"> <div style="margin-right: 10px;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div> <p>a. HEPATIC ENCEPHALOPATHY Due to (or as a consequence of):</p> <p>b. LIVER CIRRHOSIS Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> </div> | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  HOUSESTAFF INT. MEDICINE | | 29c. License number P 10056 | | 29d. Date signed (Month, Day, Year) AUGUST, 20, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANITA NAHAR, 3001 S-HANDOVER STREET, BALTIMORE MD 21225 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature  | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

26644

| | | | | | | | | |
|--|--|---------------------------------------|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BETTY LOIS HAPPEL | | | | 2. Date of Death Month Day Year AUGUST 23, 1999 | | 3. Time of Death 9:00 PM | |
| | 4a. Facility Name (If not institution, give street and number) CHESAPEAKE HOSPICE HOUSE | | | | 4b. City, Town, or Location of Death LINTHICUM | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 212-20-3532 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) NOV. 14, 1926 | |
| | 9. Birthplace (State or Foreign Country) PENNSYLVANIA | | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location SEVERN | |
| To Be Completed by Funeral Director | Usual Residence of Decedent 8025 QUARTERFIELD ROAD | | | | 10f. Zip Code 21144 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) HOMEMAKER | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWN HOME | | 16b. Kind of Business/Industry OWN HOME | | | |
| | 17. Father's Name (First, Middle, Last) GEORGE E. WALLS | | | | 18. Mother's Name (First, Middle, Maiden Surname) EDNA M. CLAPPER | | | |
| | 19a. Informant's Name/Relationship (Type, Print) MR. WILLIAM DEMASTUS (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 RENE AVENUE, BALTIMORE, MARYLAND 21225 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY | | Date 8/27/99 | | 20c. Location - City or Town, State BROOKLYN PARK, MD. | |
| | 21. Signature of Funeral Director | | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Myeloma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number 016364 | | 29d. Date signed (Month, Day, Year) 8/24/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. PETER R. GRAZE, M.D., 900 BESTGATE ROAD, SUITE 300, ANNAPOLIS, MD. 21401 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26645

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marcia Hartlove

2. Date of Death

August

Day

16th

Year

1999

3. Time of Death

4:03 PM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

216-48-9251

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

06-29-1952

9. Birthplace (State or Foreign Country)

TURKEY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HOWARD

10c. City, Town or Location

ELKRIDGE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6525 FALLSTON ROAD

10f. Zip Code

21075

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

SCHOOL BUS DRIVER

16b. Kind of Business/Industry

SCHOOL BUS
TRANSPORTATION

17. Father's Name (First, Middle, Last)

FRANK

DANIELS, JR.

HAZEL

MOYER

19a. Informant's Name/Relationship (Type, Print)

WOODROW HARTLOVE, JR. (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6525 FALLSTON ROAD, ELKRIDGE, MARYLAND 21075

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK

Date

8/21/99

20c. Location - City or Town, State

GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A.,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Adenocarcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

One week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypercalcemia

Pancreatitis

Obesity

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 41139

29d. Date signed (Month, Day, Year)

August 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard County Gen Hospital

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

Beverly P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26646

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|------------------------------|--|--|--|--|--|--|---|----|--------------------------|--|--|--|--|--|--|----------|----------------------------------|--|--|--|--|--|--|--|--|--|----|------------------------|--|--|--|--|--|--|------|----------------------------------|--|--|--|--|--|--|--|--|--|--|----|--|--|--|--|--|--|--|--|----|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) IDA MAE KIDD | | | | 2. Date of Death Month Day Year AUGUST 22, 1999 | | | | 3. Time of Death 11:15 A.M. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 6 BELVEDERE AVE. | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | | | 4c. County of Death ANNE ARUNDEL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 212-01-9426 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) MAR. 21, 1906 | | 9. Birthplace (State or Foreign Country) TENNESSEE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location GLEN BURNIE | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number 6 BELVEDERE AVE. | | | | 10f. Zip Code 21061 | | 10g. Citizen of What Country? UNITED STATES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES CLERK | | | | 16b. Kind of Business/Industry WHOLESALE SALES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) THURMAN FERGUSON | | | | 18. Mother's Name (First, Middle, Maiden Surname) BETTY SAIFFLETTE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) BETTY BOWMAN / FRIEND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7959 QUEENS RD., GLEN BURNIE, MARYLAND 21061 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEM. PARK | | Date AUG. 25 1999 | | 20c. Location - City or Town, State GLEN BURNIE, MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td colspan="7">Congestive Heart Failure</td> <td>3 months</td> </tr> <tr> <td colspan="10">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td colspan="7">Valvular Heart Disease</td> <td>year</td> </tr> <tr> <td colspan="10">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td colspan="7"></td> <td></td> </tr> <tr> <td>d.</td> <td colspan="7"></td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | Congestive Heart Failure | | | | | | | 3 months | Due to (or as a consequence of): | | | | | | | | | | b. | Valvular Heart Disease | | | | | | | year | Due to (or as a consequence of): | | | | | | | | | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | | | | | | | | | d. | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | a. | Congestive Heart Failure | | | | | | | 3 months | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. | Valvular Heart Disease | | | | | | | year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury M | | 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D2384 | | | 29d. Date signed (Month, Day, Year) AUGUST 23, 1999 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONATHAN FORMAN, M.D., 1406 B CRAIN HWY., SUITE 304, GLEN BURNIE, MD 21061 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26647

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Anna Klaschus | | | | 2. Date of Death Month August Day 19 Year 1999 | | 3. Time of Death 6:03pm | |
| 4a. Facility Name (If not institution, give street and number) St. Elizabeth's Nursing Home | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | |
| 5. Social Security Number 215-01-3623 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 91 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 1, 1907 | 9. Birthplace (State or Foreign Country) MD. |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD. | | 10b. County St. Mary's | | 10c. City, Town or Location Leonardtown | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number Rt. 1, Box 108-3AB | | | | 10f. Zip Code 20650 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) salesperson | | 16b. Kind of Business/Industry department stores | |
| 17. Father's Name (First, Middle, Last) Vincent Waitukaitis | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Palovis | | | |
| 19a. Informant's Name/Relationship (Type, Print) Raymond Klaschus son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 Lee Avenue, Sykesville, Md. 21784 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer Cem. | | Date 8/23/99 | | 20c. Location - City or Town, State Baltimore, Md. | |
| 21. Signature of Funeral Service Licensee Hande L Lemmer | | | | 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, Md. 21228 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Senile Dementia, Alzheimer, End-stage Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier Benjamin S. Lee, MD | | | | 29c. License number D52544 | | 29d. Date signed (Month, Day, Year) AUG, 20, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin S. Lee, MD 520 N. Rolling Rd #4, Catonsville, MD 21228 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature Anna B. Sparks | | | | | |

Klaschus, Anna
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Michael Timothy Kreis

AMEND ITEMS: #23 PART I, 27 PER MEO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26648

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Michael Kreis | | | | 2. Date of Death Month Day Year August 17, 1999 | | | | 3. Time of Death 11:40 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number) 8 Valley Frost Court, Apartment H | | | | 4b. City, Town, or Location of Death Cockeysville | | | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 210-64-2460 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 31 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 25, 1968 | | 9. Birthplace (State or Foreign Country) PA | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Cockeysville | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 8 Valley Frost Court (Apt.- H) | | | | 10f. Zip Code 21030 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bio-Medical Tech. | | | | 16b. Kind of Business/Industry Hospital | | | |
| 17. Father's Name (First, Middle, Last) Robert A. Kries | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marie C. Buckley | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Timothy P. Kreis / Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 231 West Drinker Street, Dunmore PA | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dunmore Cemetery | | Date August 21, 1999 | | 20c. Location - City or Town, State Dunmore, PA | | | | | |
| 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. | | | | 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DIABETES MELLITUS | | | | | | | | | | Approximate Interval Between Onset and Death | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier Wm. J. Melville | | | | 29c. License number O.C.M.E. | | | | 29d. Date signed (Month, Day, Year) August 18, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. A. KORSW 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

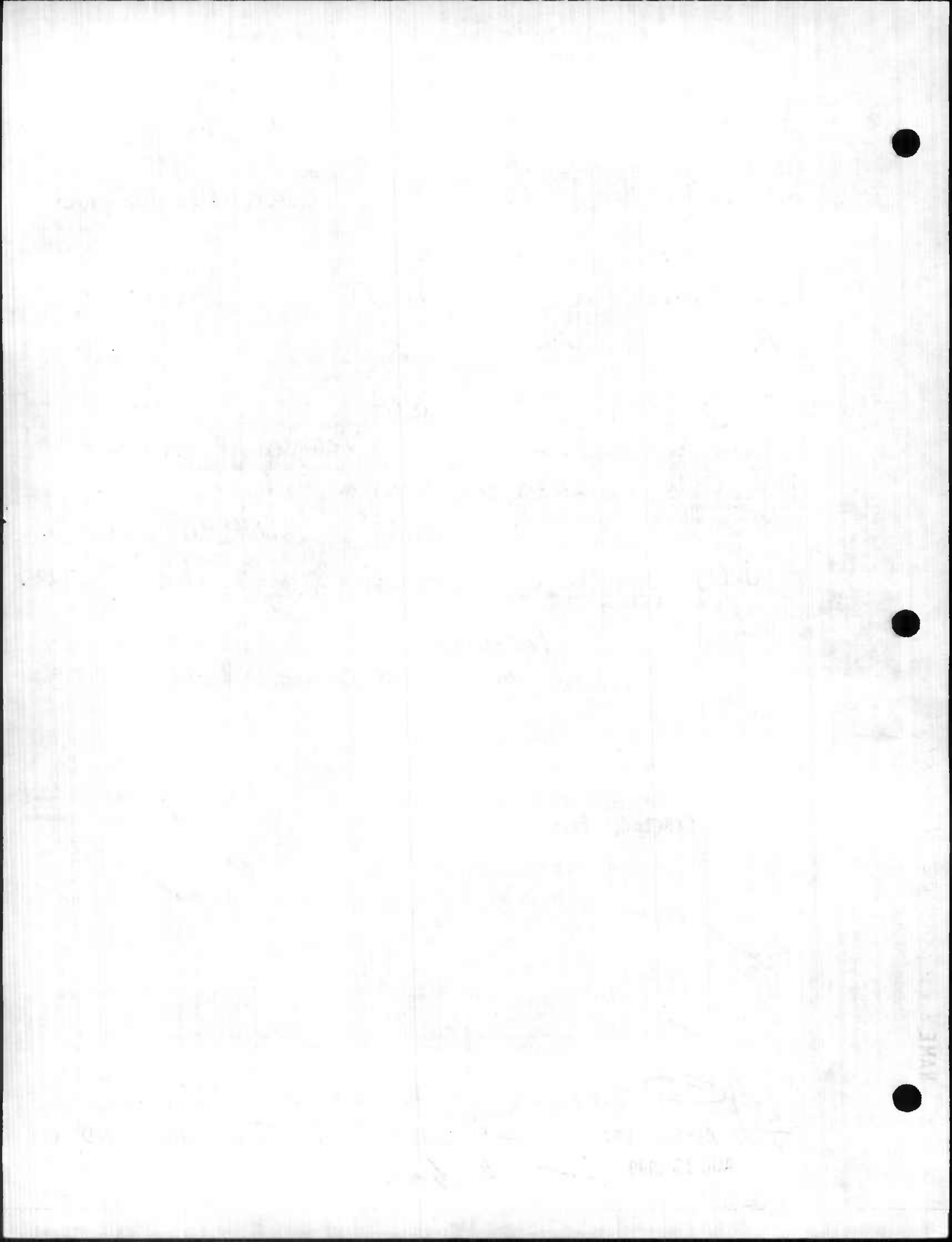
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26649

| | | | | | | | | | | | |
|---|---|--|---|--|---|--|---|---|--|--|--|
| Physician /Medical Examiner | Decedent's Name (First, Middle, Last) Franklin Karpowicz | | | | 2. Date of Death Month Aug Day 23 Year 1999 | | | | 3. Time of Death 3:30 pm | | |
| | 4a. Facility Name (If not institution, give street and number) ST. Agnes Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death NIA | | |
| Funeral Director | 5. Social Security Number 215-05-5347 | | 6. Sex M <input type="checkbox"/> F <input type="checkbox"/> | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) 05-07-1933 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County NIA | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 3320 Benson Ave. | | | | 10f. Zip Code 21227 | | 10g. Citizen of What Country? United States | | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NIA | | | | 16b. Kind of Business/Industry NIA | | |
| | 17. Father's Name (First, Middle, Last) Adam Karpowicz | | | | 18. Mother's Name (First, Middle, Maiden Surname) Veronica Michalski | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Kristen Combs / social worker | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3320 Benson Ave. Baltimore, MD 21227 | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St Stanislas | | | | 20c. Location: City or Town, State Baltimore, MD | | 20d. Date 8/23/99 | | |
| | 21. Signature of Funeral Service Licensee Dean Subage | | | | 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): RIGHT HIP AND KNEE CONTRACTURE RELEASE Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CEREBRAL PALSY Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 4 days | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CEREBRAL PALSY | | | | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier JOHN ANTONIADIS | | | | 29c. License number AU416VJ5A9992 | | 29d. Date signed (Month, Day, Year) 8/23/99 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN ANTONIADIS 3507 N. CHARLES ST Apt T101, BALTIMORE, MD 21218 | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 25 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26650

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|--|---|--|--|--------------------------------|--|--|-----------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James Lumpkins | | | | 2. Date of Death Month August Day 21 Year 1999 | | 3. Time of Death 2:00 AM | | |
| | 4a. Facility Name (If not institution, give street and number) 2416 Baker St. | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 215-10-0088A | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 94 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 30, 1905 | 9. Birthplace (State or Foreign Country) South Carolina | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 2416 Baker St. | | | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Forklift Operator | | 16b. Kind of Business/Industry Revere Copper + Brass | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Jacob Lumpkins | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lena Mobley | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) (wife) Mrs. Inez Lumpkins | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2416 Baker St. Balto. Md. 21216 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Park | | 20c. Location - City or Town, State Balto. Md. | | 20d. Date 8/27/99 | | |
| | 21. Signature of Funeral Service Licensee Joseph L. Russ | | | | 22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216 | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cancer of the lung Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death | |
| | b. Due to (or as a consequence of): | | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | | |
| | d. Due to (or as a consequence of): | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| | 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| | 29b. Signature and title of certifier Bernard R Rogers MD | | | | 29c. License number D47422 | | 29d. Date signed (Month, Day, Year) August 25, 1999 | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bernard R Rogers MD 821 NEvtaw St. Balto, md 21201 | | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature Bernard R. Sparks | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26651

| | | | | | |
|---|---|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Dorothy</u> | | 2. Date of Death Month <u>August</u> Day <u>23</u> Year <u>1999</u> | | 3. Time of Death <u>7:10A</u> |
| | 4a. Facility Name (If not institution, give street and number) <u>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</u> | | 4b. City, Town or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>N/A</u> |
| Funeral Director | 5. Social Security Number <u>215-07-4268</u> | 6. Sex <u>1</u> M <u>2</u> F | 7. Age (In yrs. last birthday) <u>85</u> Yrs. | 8. Date of Birth (Month, Day, Year) <u>July 11, 1914</u> | 9. Birthplace (State or Foreign Country) <u>Maryland</u> |
| | Usual Residence of Decedent | | | | |
| 10a. State <u>Maryland</u> | | 10b. County <u>Baltimore</u> | | 10c. City, Town or Location <u>Edgemere</u> | |
| 10d. Inside City Limits <u>1</u> Yes <u>2</u> No | | | | | |
| 10e. Street and Number <u>2825 Lodge Farm Road Apt. 112</u> | | 10f. Zip Code <u>21219</u> | | 10g. Citizen of What Country? <u>United States</u> | |
| 11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 Years</u> College (1-4 or 5+) <u>College</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u> | | 16b. Kind of Business/Industry <u>Own Home</u> | |
| 17. Father's Name (First, Middle, Last) <u>Matthew Connors</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Estella Franz</u> | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Dolores M. Skalski</u> <u>Daughter</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>8157 Gray Haven Road Dundalk, Maryland 21222</u> | | | |
| 20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Sacred Ht. of Jesus Cem.</u> | | 20c. Location - City or Town, State <u>Dundalk, Maryland</u> | |
| 21. Signature of Funeral Service Licensee <u>[Signature]</u> | | 22. Name and Address of Facility <u>Duda-Ruck Funeral Home of Dundalk, Inc.</u> <u>7922 Wise Ave. Dundalk, Maryland 21222</u> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. PNEUMONIA</u> Due to (or as a consequence of): <u>b. CEREBROVASCULAR ACCIDENT</u> Due to (or as a consequence of): <u>c.</u> Due to (or as a consequence of): <u>d.</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death <u>3 DAYS</u> <u>9 DAYS</u> | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown | | | |
| | | 24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No | | | |
| | | 24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No | | | |
| 25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No | | 26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) | | | |
| 27. Manner of Death <u>1</u> Natural <u>5</u> Pending investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <u>M</u> | |
| | | 28c. Injury at Work? <u>1</u> Yes <u>2</u> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <u>1</u> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <u>[Signature] MD</u> | | 29c. License number <u>20313</u> | | 29d. Date signed (Month, Day, Year) <u>August 23, 1999</u> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>David A. Rapko</u> <u>4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</u> | | | | | |
| 31. Date filed (Month, Day, Year) <u>AUG 25 1999</u> | | 32. Registrar's Signature <u>[Signature]</u> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

And 6

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26652

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GENEVA MARTIN

2. Date of Death

Month Day Year

AUGUST 22 1999

3. Time of Death

7:15 AM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

220-07-5441

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

05 24 16

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3215 Carlisle Ave

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th grade

na

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Domestic Worker

16b. Kind of Business/Industry

Private Family

17. Father's Name (First, Middle, Last)

Isiah McDowell

18. Mother's Name (First, Middle, Maiden Surname)

Sallie Moore

19a. Informant's Name/Relationship (Type, Print)

Sheila Martin-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3215 Carlisle Ave, Baltimore Md 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park 8/27/99 Randallstown, Md

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Blondie Wane

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore Md 21215

Approximate
Interval Between
Onset and Death

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

SEPSIS

Due to (or as a consequence of):

b.

CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c.

HYPERTENSION

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. S. Spinks

29c. License number

A52402321-SP9206

29d. Date signed (Month, Day, Year)

AUGUST 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401 WEST BELVEDERE AVENUE, BALTIMORE, MARYLAND 21215

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

S. S. Spinks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

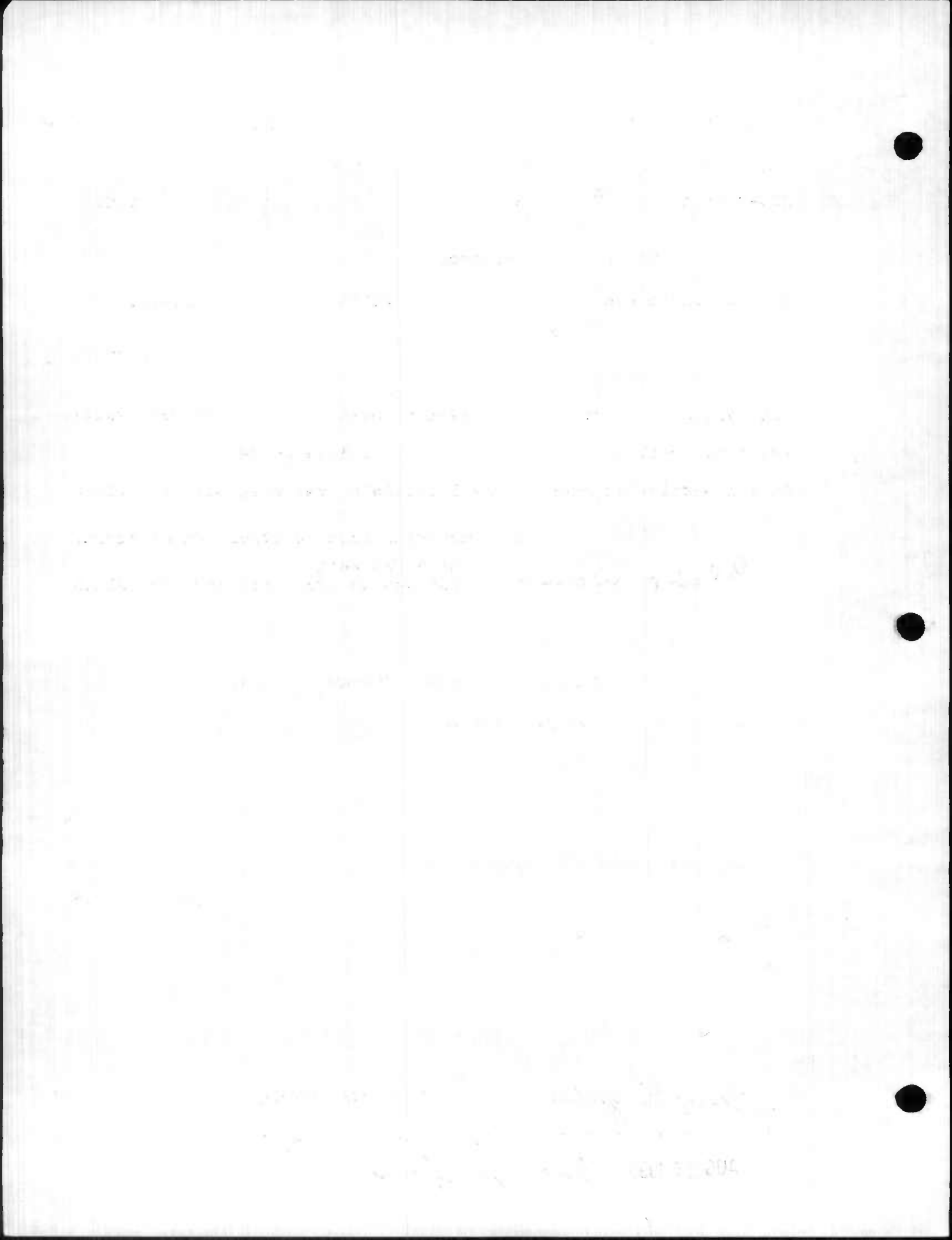
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26653

AMEND ITEM: #1 PER MD G774 8-25-99 WR.

Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>JESSE MOGOL</u> | | 2. Date of Death Month <u>August</u> Day <u>15</u> Year <u>1999</u> | | 3. Time of Death <u>0636</u> |
| | 4a. Facility Name (If not institution, give street and number) <u>Sinai Hospital of Baltimore</u> | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>N/A</u> |
| Funeral Director | 5. Social Security Number <u>219-16-8065</u> | 6. Sex <u>1</u> M <u>2</u> F | 7. Age (In yrs. last birthday) <u>90</u> Yrs. | 8. Date of Birth Month <u>4</u> Day <u>26</u> Year <u>1909</u> | 9. Birthplace (State or Foreign) <u>MARYLAND</u> |
| | Usual Residence of Decedent | | | | |
| 10a. State <u>MD</u> | | 10b. County <u>BALTIMORE</u> | | 10c. City, Town or Location <u>BALTIMORE</u> | |
| 10d. Inside City Limits <u>1</u> Yes <u>2</u> No | | | | | |
| 10e. Street and Number <u>2311 HANWAY ROAD</u> | | 10f. Zip Code <u>21209</u> | | 10g. Citizen of What Country? <u>USA</u> | |
| 11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify <u>WHITE</u> | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>MERCHANT</u> | | 16b. Kind of Business/Industry <u>RETAIL</u> | |
| 17. Father's Name (First, Middle, Last) <u>MORRIS</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>MARY</u> | | <u>ALTSCHUL</u> | |
| 19a. Informant's Name/Relationship (Type, Print) <u>ALAN MOGOL/ SON</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>8206 SPRING BOTTOM WAY BALTIMORE, MD. 21208</u> | | | |
| 20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>B'NAI ISRAEL CONGREGATION</u> | | 20c. Location - City or Town, State <u>8/17/99 BALTIMORE, MD.</u> | |
| 21. Signature of Funeral Service Licensee <u>[Signature]</u> | | 22. Name and Address of Facility <u>SOL LEVINSON & BROS. INC.</u> <u>8900 REISTERSTOWN RD. PIKESVILLE, MD. 21208</u> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | a. <u>Ischemic Bowel</u> Due to (or as a consequence of): | | Hours | |
| | | b. <u>Coronary Artery Disease</u> Due to (or as a consequence of): | | Years | |
| | | c. _____ Due to (or as a consequence of): | | | |
| | | d. _____ Due to (or as a consequence of): | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown | |
| | | | | 24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No | |
| 25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No | | 26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) | | | |
| 27. Manner of Death <u>1</u> Natural <u>5</u> Pending investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <u>M</u> | |
| | | 28c. Injury at Work? <u>1</u> Yes <u>2</u> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <u>2</u> Medical Examiner | | 29b. Signature and title of certifier <u>[Signature]</u> | | | |
| | | 29c. License number <u>D0053607</u> | | 29d. Date signed (Month, Day, Year) <u>August 15, 1999</u> | |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print) <u>Paul Burns 7505 Oster Drive Suite 306 Towson, MD</u> | | | | | |
| 31. Date filed (Month, Day, Year) <u>AUG 25 1999</u> | | 32. Registrar's Signature <u>[Signature]</u> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

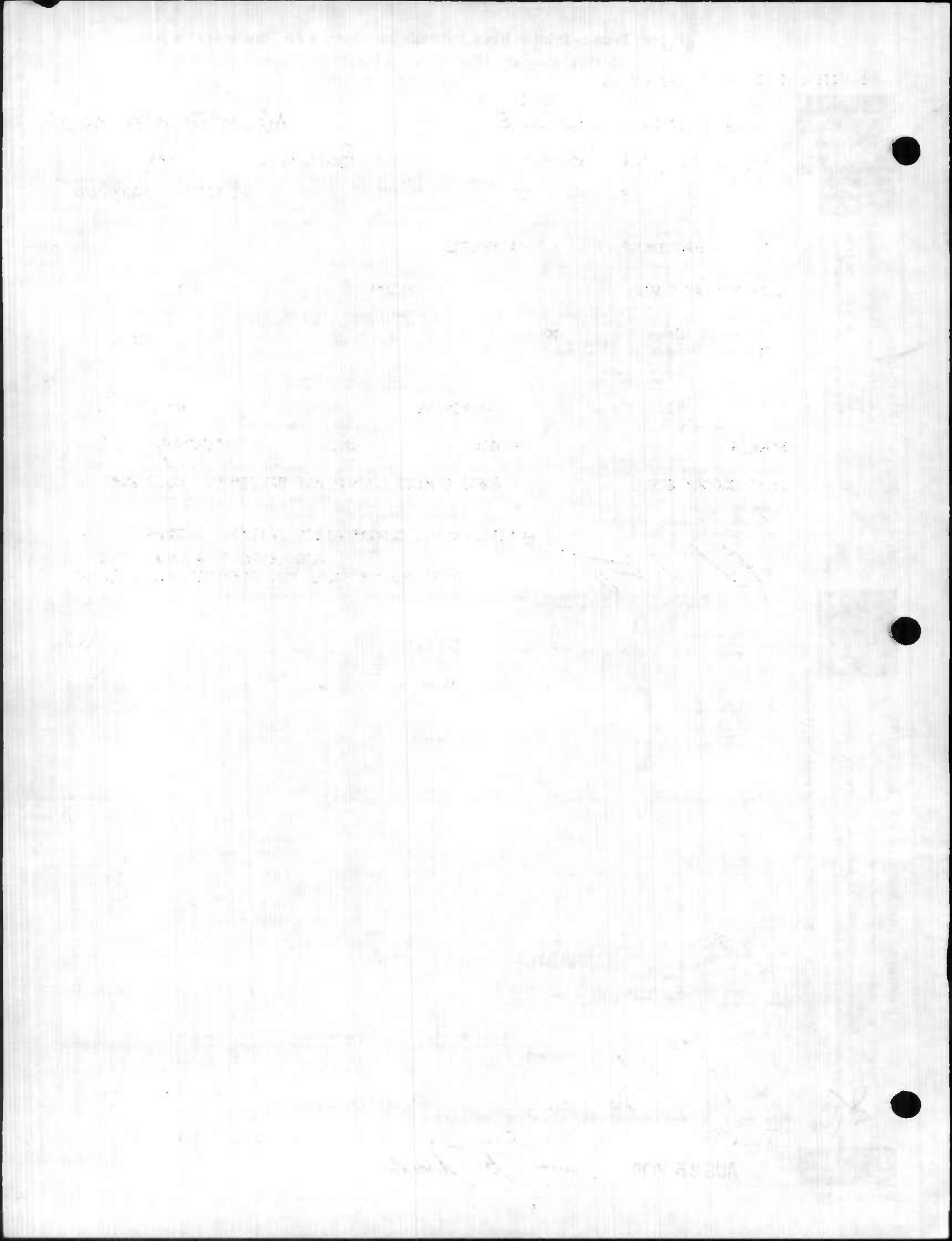
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26654

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MICHAEL E. MARTINO

2. Date of Death

August 22, 1999

3. Time of Death

2:25 PM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

439-63-2569

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 14, 1942

9. Birthplace (State or Foreign Country)

CALIFORNIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

MILLERSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

505 CHALET DRIVE

10f. Zip Code

21108

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify: WHITE14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

MANAGER OF INSTALLATION

16b. Kind of Business/Industry

CABLE TV INDUSTRY

17. Father's Name (First, Middle, Last)

LEO

MARTINO

18. Mother's Name (First, Middle, Maiden Surname)

HELEN

SANCHEZ

19a. Informant's Name/Relationship (Type, Print)

VERNA D. MARTINO (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

505 CHALET DRIVE, MILLERSVILLE, MD. 21108

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHESAPEAKE CREMATION CENTER LLC.

Date

8/24/99

20c. Location - City or Town, State

STEVENSVILLE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A.,
1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 2106123a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Multiorgan Organ Failure

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Sepsis

Due to (or as a consequence of):

c. Gangrene of Intestine

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D51596

29d. Date signed (Month, Day, Year)

August 22nd 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. Ambalavanar, North Arundel Hospital, 301 Hospital Drive, Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26655

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sadie Anne McGraw

2. Date of Death

August 19, 1999 11:40am

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

220-36-8300

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 2, 1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5815 Plumer Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Medical Records

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Charles F. Pfister

18. Mother's Name (First, Middle, Maiden Surname)

Rose E. Phillips

19a. Informant's Name/Relationship (Type, Print)

Mr. Kevin P. McGraw / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as item 10e.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cemetery 8/23/99 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Timothy Harman

22. Name and Address of Facility

Leonard J. Ruck, Inc. Funeral Home
5305 Harford Road Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Melanoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

RD 196642

29d. Date signed (Month, Day, Year)

08-19-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Luis Lopez 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

[Signature] B. Sparks

State
Registrar

McGraw, Sadie
Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-224-2200.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 26656**
Certificate of Death

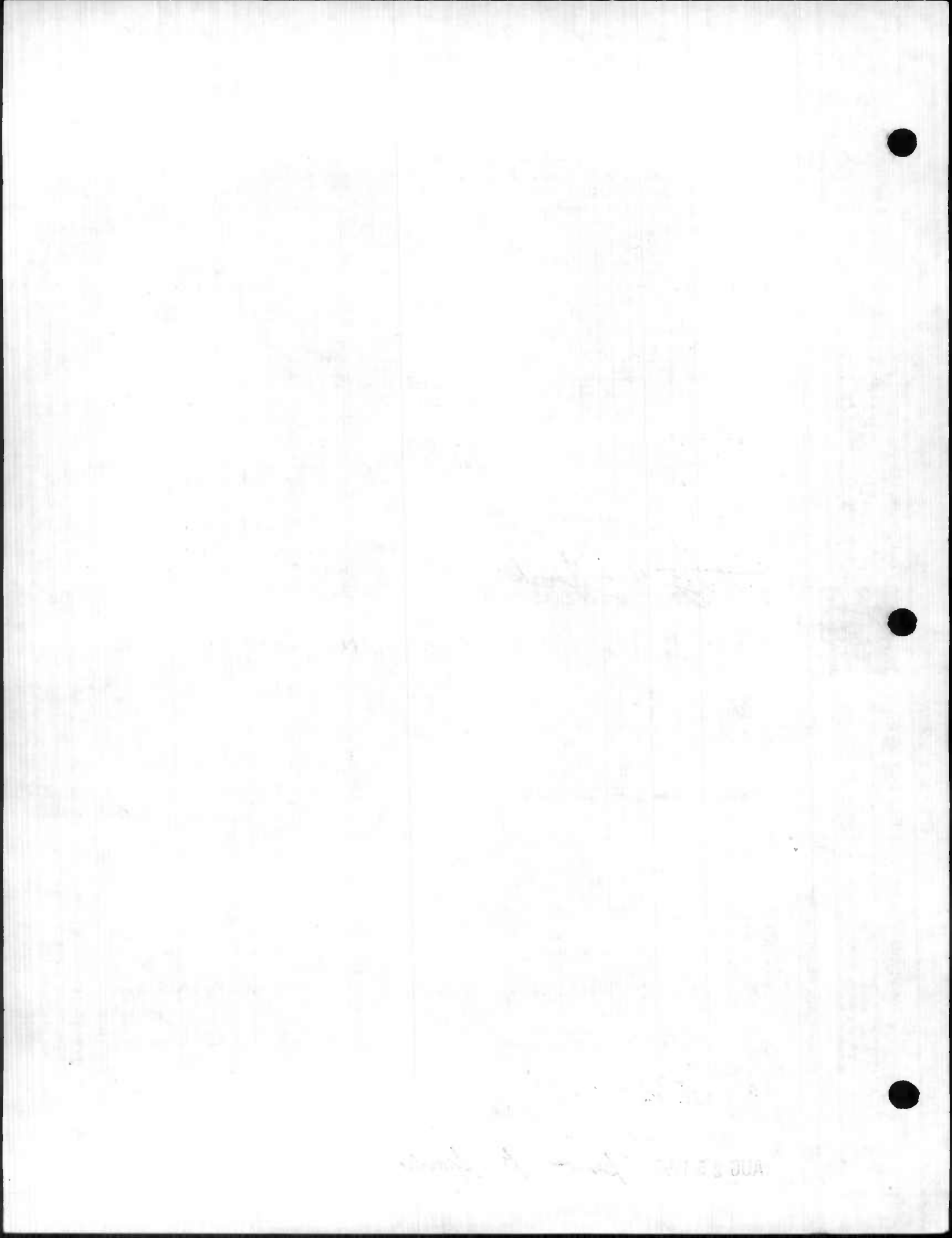
Reg. No.

| | | | | | | | | | | |
|---|---|--|---|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Theresa R. Nadolny | | | | 2. Date of Death Month August Day 21 , Year 1999 | | | | 3. Time of Death 9:00 PM | |
| | 4a. Facility Name (If not institution, give street and number) Lorien Nursing and Rehabilitation Center | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 220-24-0246 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 71 Yrs. | | 8. Date of Birth (Month, Day, Year) 8/2/1928 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 3 Propeller Drive | | | | 10f. Zip Code 21220 | | | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress | | | | 16b. Kind of Business/Industry Overlea Caterers | | |
| 17. Father's Name (First, Middle, Last) Alexander Campoli | | | | 18. Mother's Name (First, Middle, Maiden Surname) Julia Furini | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Dolores Lurz | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2249 Firethorn Road Baltimore, Maryland 21220 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oaklawn Cemetery | | | Data 8/25/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 | | | | | | |
| 23a. Part I: Enter immediate cause, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. METASTATIC LUNG CANCER Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> <div style="width: 35%; border-left: 1px dashed black; padding-left: 5px;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D52228 | | 29d. Date signed (Month, Day, Year) 8/24/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VINUKUMAR BHADNA MD 3007 E-NORTHERN PKWY, BALTIMORE, 21214 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26657
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS LOUISE OBIE

2. Date of Death

Month Day Year
AUGUST 21, 1999

3. Time of Death

01:20A-M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH CARE

4b. City, Town, or Location of Death

GLEN BURNIE A.A. COUNTY

4c. County of Death

5. Social Security Number

220-14-7454

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JAN. 25, 1924

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

437 SWALES AVENUE

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

FOOD SERVICE

16b. Kind of Business/Industry

BALTIMORE CITY

17. Father's Name (First, Middle, Last)

WEBSTER

STANLEY

18. Mother's Name (First, Middle, Maiden Surname)

GRACE I. COOK

19a. Informant's Name/Relationship (Type, Print)

DORIS BURRIS (NIECE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

437 SWALES AVE., BALTIMORE, MARYLAND 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

BALTIMORE NATIONAL CEMETERY - 25-99 BALTIMORE, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

JOSEPH H. CROWN JR. FUNERAL HOME
2140 N. FULTON AVENUE, BALTIMORE, MD 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CARCINOMA OF GALL BLADDER

Approximate
Interval Between
Onset and Death

1 MONTH

Due to (or as a consequence of):

b. LIVER METASTASIS

1 MONTH

Due to (or as a consequence of):

c. ESSENTIAL HYPERTENSION

8 YEARS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] ATTENDING PHYSICIAN
M.D.

29c. License number

D14160

29d. Date signed (Month, Day, Year)

August 21, 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARJIT SINGH M.D. 5410-A RITCHIE HIGHWAY, BALTIMORE
MARYLAND - 21225.State
Registrar

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

[Signature]

DORIS LOUISE OBIE

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26658

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | |
|--|--|--|---|---|--|--------------------------|--|--|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ANNA PAXTON | | | | 2. Date of Death Month Day Year 8 23 99 | | | | 3. Time of Death 10:11 AM | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) BON SECOURS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death N/A | | | | | | |
| Funeral Director | 5. Social Security Number 219-42-6258 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 | | 8. Date of Birth (Month, Day, Year) July 26, 1917 | | 9. Birthplace (State or Foreign Country) Virginia | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| | 10e. Street and Number 2026 Payson St. | | | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? USA | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Afro-American | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Claims Adjustor | | | 16b. Kind of Business/Industry Social Security Adm. | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Nathan T. Thornton | | | | 18. Mother's Name (First, Middle, Maiden Surname) Martha E. Butler | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mrs. Patricia Miller (niece) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3700 Greenspring Ave. Apt. 202 Balto. Md. 21211 | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest | | 20c. Date 8/30/99 | | 20d. Location - City or Town, State Dwings Mills, Md. | | | | | | | | |
| | 21. Signature of Funeral Service Licensee Joseph L. Russ | | | | 22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216 | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCLEROTIC CARDIO VASCULAR DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION TYPE 2 DIABETES MELLITUS PARKINSON'S DISEASE ; UROSEPSIS | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. Signature and title of certifier Thomas S. Miller, MD | | 29c. License number D30272 | | 29d. Date signed (Month, Day, Year) AUG 23, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) THOMAS S. MILLER BON SECOURS HOSPITAL BALTIMORE, MD. | | | | | | | | | | 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature B. Sparks | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26659

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jake C. Price

2. Date of Death

August 23 1999

3. Time of Death

11:08 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

214-86-6161

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

33

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

12-15-65

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2725 Pelham Street

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th Grade

College (1-4 or 5+)

NA

16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Banquet Houseman

16b. Kind of Business/Industry

Omni Hotel

17. Father's Name (First, Middle, Last)

Jake Price

18. Mother's Name (First, Middle, Maiden Summa)

Mamie Jones

19e. Informant's Name/Relationship (Type, Print)

Sarah Price

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2725 Pelham Avenue Baltimore, Maryland

21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Voshell Mem. Gardens

Date

08-28-99

20c. Location - City or Town, State

Dundalk, MD

21. Signature of Funeral Service Licensee

James

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C.March FH 1101 E. North Avenue

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. ARDS

Due to (or as a consequence of):

b. Septic Shock

Due to (or as a consequence of):

c. Acute Pancreatitis

Due to (or as a consequence of):

d. AIDS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hepatitis - C.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28e. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Waseem

29c. License number

D 52323

29d. Date signed (Month, Day, Year)

8/23/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Waseem 18601 Koxbury Rd. Hager, Md

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

PRICE Jake C.

AHZ

1. The first part of the report is devoted to a description of the

methods used in the investigation.

2. The second part contains a summary of the results obtained.

3. The third part is a discussion of the results.

4. The fourth part is a conclusion.

5. The fifth part is a list of references.

6. The sixth part is a list of symbols.

7. The seventh part is a list of abbreviations.

8. The eighth part is a list of figures.

9. The ninth part is a list of tables.

10. The tenth part is a list of appendices.

11. The eleventh part is a list of footnotes.

12. The twelfth part is a list of references.

13. The thirteenth part is a list of symbols.

14. The fourteenth part is a list of abbreviations.

15. The fifteenth part is a list of figures.

16. The sixteenth part is a list of tables.

17. The seventeenth part is a list of appendices.

18. The eighteenth part is a list of footnotes.

19. The nineteenth part is a list of references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26660

| | | | | | | | | |
|--|--|---|--|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BLANNIE E. PEELE | | | | 2. Date of Death Month Day Year AUGUST 19, 1999 | | 3. Time of Death 3:15 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) CATON MANOR GENESIS ELDERCARE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 212-14-8511 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 93 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) MARCH 14, 1906 | 9. Birthplace (State or Foreign Country) NORTH CAROLINA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 4 BRUBAR COURT, APT. 2A | | | | 10f. Zip Code 21207 | | 10g. Citizen of What Country? USA. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6TH GRADE College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSE KEEPER | | 16b. Kind of Business/Industry SELF-EMPLOYED | | |
| 17. Father's Name (First, Middle, Last) ANDREW | | | | 18. Mother's Name (First, Middle, Maiden Surname) ELLA (MN-UNKNOWN) | | | | |
| 19a. Informant's Name/Relationship (Type, Print) VERNON J. PEELE (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 BRUBAR COURT, APT. 2A, BALTIMORE, MD 21207 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) DRUID RIDGE CEMETERY | | 20c. Date 8-23-99 | | 20d. Location - City or Town, State BALTIMORE MARYLAND | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD 21217 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Colon carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D-40521 | | 29d. Date signed (Month, Day, Year) August 20, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. OCHANAY | | | | 31. Date filed (Month, Day, Year) AUG 25 1999 | | | | |
| 32. Registrar's Signature | | | | 33. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3350 Wilkens Avenue Suite 302 Baltimore, MD 21229 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

100-122

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26661

| | | | | | |
|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BEREL | | 2. Date of Death Month Day Year AUGUST 22, 1999 | | 3. Time of Death 9:50 AM |
| | 4a. Facility Name (If not institution, give street and number) BRIGHTWOOD MERIDIAN NURSING HOME | | 4b. City, Town, or Location of Death LUTHERVILLE | | 4c. County of Death BALTIMORE |
| Funeral Director | 5. Social Security Number 150-07-6025 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) APR. 12, 1918 | | 9. Birthplace (State or Foreign Country) RUSSIA | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State MD | 10b. County N/A | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number 2500 W. BELVEDERE AVENUE #818 | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER | | 16b. Kind of Business/Industry CONFECTIONERY STORE | | |
| | 17. Father's Name (First, Middle, Last) MICHAEL | | 18. Mother's Name (First, Middle, Maiden Surname) BETH (UNKNOWN) | | |
| | 19e. Informant's Name/Relationship (Type, Print) PENNY PATRICK / DAUGHTER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 STEEPLE JACK COURT - OWINGS MILLS, MD 21117 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BETH HAMEDROSH HAGODOL | | 20c. Location - City or Town, State 8/23/99 ROSEDALE, MD |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | |
| Physician /Medical Examiner | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death |
| | a. Respiratory arrest + failure Due to (or as a consequence of): days | | | | |
| | b. Amyotrophic Lateral Sclerosis Due to (or as a consequence of): years | | | | |
| | c. Due to (or as a consequence of): | | | | |
| | d. Due to (or as a consequence of): | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cerebrovascular disease | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D07421 | | 29d. Date signed (Month, Day, Year) 8-22-99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 Greentree Rd #300 Baltimore Md 21208 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

24
AMEND ITEM: #25 PER VERBAL RESPONSE G774 8-25-99 WR.

Certificate of Death

Reg. No.

99 26662

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | | | |
|--|---|---|--|---|--|--|--------------------------------|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Philip Richman | | | | 2. Date of Death Month Day Year August 16 1999 | | | | 3. Time of Death 0418 | | |
| | 4a. Facility Name (If not institution, give street and number) Atlantic Hospital | | | | 4b. City, Town, or Location of Death Berlin | | | | 4c. County of Death Worcester | | |
| Funeral Director | 5. Social Security Number 219-05-5742 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | |
| | 8. Date of Birth (Month, Day, Year) Oct. 4, 1918 | | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Worcester | | 10c. City, Town or Location Ocean City | | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 13800 Derrickson Avenue | | 10f. Zip Code 21842 | | 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-45 | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pharmacist | | 16b. Kind of Business/Industry Pharmaceutical | | 17. Father's Name (First, Middle, Last) Hyman Richman | |
| 18. Mother's Name (First, Middle, Maiden Surname) Jenny Kipnis | | 19a. Informant's Name/Relationship (Type, Print) Thelma Kahn Richman (Wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13800 Derrickson Avenue, Ocean City, MD 21842 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery | | 20c. Location - City or Town, State 08/18 Crownsville, MD | |
| 21. Signature of Funeral Service Licensee <i>Thomas A. Hardesty</i> | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>CONGESTIVE HEART FAILURE</u> Due to (or as a consequence of): b. <u>ISCHEMIC CARDIOMYOPATHY</u> Due to (or as a consequence of): c. <u>CORONARY ARTERY DISEASE</u> Due to (or as a consequence of): d. <u>ASCVD</u> | | Approximate Interval Between Onset and Death YRS YRS YRS | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>D.J. Chodnicki</i> | |
| 29c. License number 1020912 | | 29d. Date signed (Month, Day, Year) 8-16-99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.J. Chodnicki, M.D. Berlin Prof. Center, Franklin Ave., #107, Berlin, MD 21811 | | 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | State Registrar | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26663

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) SARAH Arlean Redmond | | | | 2. Date of Death Month Day Year August 23, 1999 | | | | 3. Time of Death 12:15 AM | |
| | 4a. Facility Name (If not institution, give street and number) STELLA MARIS Hospice at Mercy | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 223-22-5099 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) May 15, 1923 | | 9. Birthplace (State or Foreign Country) Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 1805 East Federal Street | | | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) Admin. Asst. Nursing Div | | | | 16b. Kind of Business/Industry Johns Hopkins Hospital | |
| | 17. Father's Name (First, Middle, Last) Roosevelt Hobbs | | | | 18. Mother's Name (First, Middle, Maiden Surname) Olivia Johnson | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Stephanie DENISE Gilliam | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1805 E. Federal St. Balto. Md. 21213 | | | | | |
| Physician /Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Park | | 20c. Location - City or Town, State Arbutus, Md. | | 20d. Date 8/26/99 | | | |
| | 21. Signature of Funeral Service Licensee Blair Adams | | | | 22. Name and Address of Facility MARSHALL W. SONES JR. E.H. PA 401 Edmondson Ave. Balto. Md 21229 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | |
| State Registrar | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) STELLA MARIS at MERCY HOSPICE | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier Du Ruy m | | | | 29c. License number D40854 | | 29d. Date signed (Month, Day, Year) August 23, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID RISEBERG 301 St Paul P/ BALTIMORE, MD 21302 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 24 1999 | | | | | | | | | |

1900 - 1901
1902 - 1903
1904 - 1905

1906 - 1907
1908 - 1909
1910 - 1911

1912 - 1913
1914 - 1915
1916 - 1917

1918 - 1919
1920 - 1921
1922 - 1923

1924 - 1925
1926 - 1927
1928 - 1929

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26664

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GERTRUDE M. RASPA

2. Date of Death

Month Day Year
AUGUST 24 1999 1:35am

3. Time of Death

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

AACOUNTY

Funeral
Director

5. Social Security Number

212-18-9585

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
OCT. 6, 1922

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7807 LEYMAR ROAD

10f. Zip Code

21060

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SEAMSTRESS

16b. Kind of Business/Industry

CLOTHING MANUFACTURING

17. Father's Name (First, Middle, Last)

PETER NOVAK

18. Mother's Name (First, Middle, Maiden Surname)

MARY SKOWRONSKI

19a. Informant's Name/Relationship (Type, Print)

THOMAS RASPA/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7807 LEYMAR ROAD GLEN BURNIE, MD 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLY ROSARY CEMETERY

Date

AUG. 27,

1999

20c. Location - City or Town, State

DUNDALK, MARYLAND

21. Signature of Funeral Service Licensee

Con L. C. Bayly

22. Name and Address of Facility

KIRKLEY-RUDDICK FUNERAL HOME P.A.

421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE RENAL DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D43977

29d. Date signed (Month, Day, Year)

August 24 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Angela Okunig: 301 Hospital Ave, Glen Burnie, MD. 21061.

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

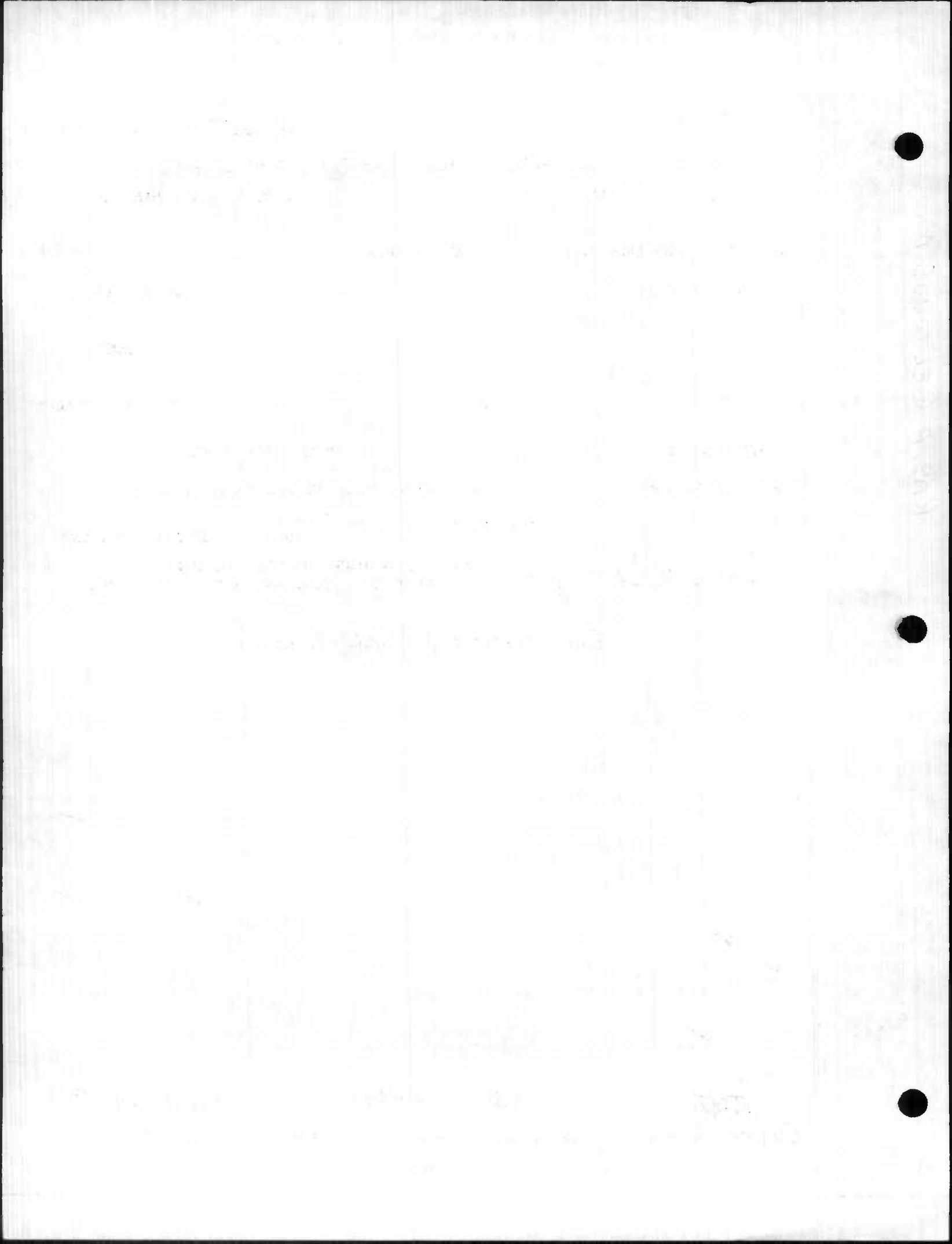
Sparks

State
Registrar

RASPA GERTRUDE M.
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26665

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Henry T. Spence

2. Date of Death

8 22 99

3. Time of Death

21:05pm

4a. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

246-16-5995

6. Sex

X ☒ M ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)

08-16-23

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1705 E. 29th Street

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Baltimore Museum of Art

17. Father's Name (First, Middle, Last)

Enoch

Spence

18. Mother's Name (First, Middle, Maiden Surname)

Rosie

Lowery

19a. Informant's Name/Relationship (Type, Print)

Roxie Brockton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1705 East 29th Street Baltimore, MD. 21218

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Baltimore Cemetery 08-27-99 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Nina Everett, MD Matilda Koval Medical Ctn. 2323 Orleans Street Baltimore, MD 21224

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #18 PER F.H. G774 8-25-99 WR.

Certificate of Death

Reg. No.

99 26666

| | | | | | |
|--|---|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HOWARD C. SACHS | | 2. Date of Death Month Day Year AUGUST 23, 1999 | | 3. Time of Death 11:10AM |
| | 4a. Facility Name (If not institution, give street and number) MANOR CARE ROLAND PARK | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 213-30-6323 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 94 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) DEC. 20, 1904 | | 9. Birthplace (State or Foreign Country) MD | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 2208 1/2 SULGRAVE AVENUE | | | 10f. Zip Code 21209 | | 10g. Citizen of What Country? U.S.A. |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER | | 16b. Kind of Business/Industry CONSTRUCTION | |
| 17. Father's Name (First, Middle, Last) JACOB SACHS | | | 18. Mother's Name (First, Middle, Maiden Surname) FANNY CAPLAN (UNKNOWN) | | |
| 19a. Informant's Name/Relationship (Type, Print) MRS. FRAN SACHS - NIECE | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54 PENNY LANE PIKESVILLE, MD 21209 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW CEMETERY | | 20c. Location - City or Town, State 8-24-99 REISTERSTOWN, MD | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. CONGESTIVE HEART FAILURE | | | Approximate Interval Between Onset and Death 2 MONTHS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. CARDIO MYOPATHY | | | 2 YEARS |
| | | c. GENERALIZED ARTERIOSCLEROSIS | | | 10 YEARS |
| | | d. | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D-22609 | | 29d. Date signed (Month, Day, Year) AUGUST 23-1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBEN REIDER M.D. 7445 FURNACE BRANCH RD GLEN BURNIE MD 21060 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26667

| | | | | | | | | |
|---|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROBERT M. STEUDL, SR. | | | | 2. Date of Death Month Day Year AUGUST 21, 1999 | | 3. Time of Death 9:20 PM | |
| | 4a. Facility Name (If not institution, give street and number) MARINER HEALTH OF GLEN BURNIE | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 217-24-6157 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 71 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN. 7, 1928 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location PASADENA | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 7829 SOUTHWEST ROAD | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 1946- If Yes, Give Year or Dates: 1947 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MECHANICAL ENGINEERING | | 16b. Kind of Business/Industry U.S. GOVERNMENT | | | | |
| 17. Father's Name (First, Middle, Last) JAMES STEUDL | | | | 18. Mother's Name (First, Middle, Maiden Surname) HELEN ELIZABETH RUMNEY | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MRS. CARLEEN STEUDL (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7829 SOUTHWEST ROAD, PASADENA, MARYLAND 21122 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY | | 20c. Date 8/26/99 | | 20d. Location - City or Town, State BALTIMORE, MD. | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary artery accident Due to (or as a consequence of): b. atrial fibrillation Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number 041927 | | 29d. Date signed (Month, Day, Year) 8/23/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jorge Perez-Alarid 3708 Mountain Rd Pasadena, Md 21122 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26668

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|--|---|--|---|--------------------------------|--|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Joseph J. Scarpulla | | | | 2. Date of Death Month Day Year August 31 1999 | | | | 3. Time of Death 9:00 AM | |
| | 4a. Facility Name (If not institution, give street and number) Stella Maris/Mercy | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 217-18-6437 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) 6/22/1922 | | 9. Birthplace (State or Foreign Country) Maryland | | Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 924 S. Robinson Street | | | | 10f. Zip Code 21224 | | | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Printer | | | | 16b. Kind of Business/Industry Printing | | |
| 17. Father's Name (First, Middle, Last) Angelo Scarpulla | | | | 18. Mother's Name (First, Middle, Maiden Surname) Josephine Veneziana | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) John Scarpulla/Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5134 Wright Avenue Baltimore, Maryland 21205 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) 1st United Evangelical | | Date 8/25/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gangrene L leg Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Probable Lymphoma. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) STELLA MARIS AT MERCY HOSPICE | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number D40854 | | |
| 29d. Date signed (Month, Day, Year) August 23, 1999 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID RISEBERG, 3015 PAUL PI BALTIMORE MD 21202 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | | | 32. Registrar's Signature | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

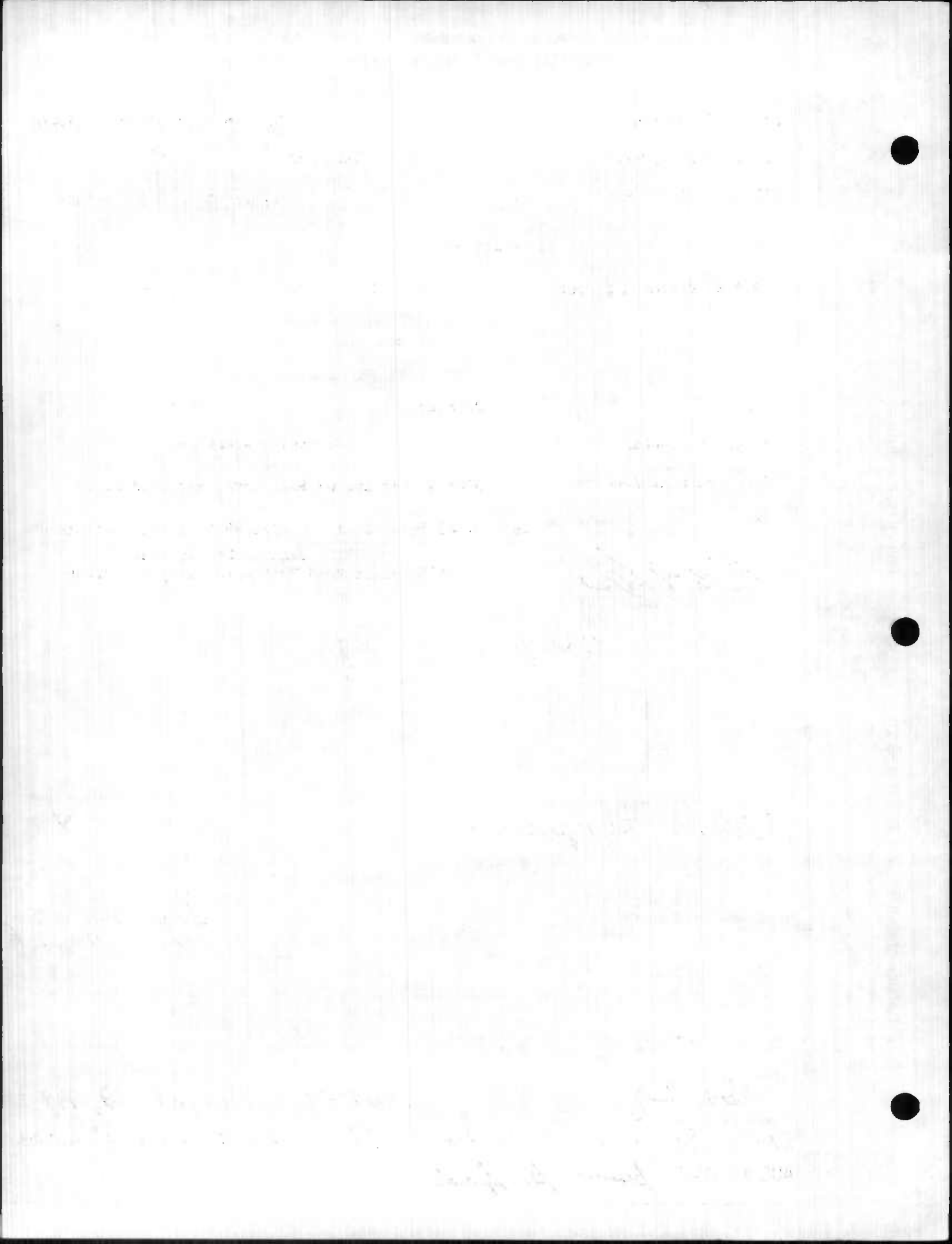
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26669

| | | | | | | | | | | | | | | | |
|--|--|--------------------------|--|---|---|--|---|--|--------------------------------|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mildred E. Schmidt | | | | | | 2. Date of Death Month Day Year August 20, 1999 | | | | 3. Time of Death 11:00 AM | | | | |
| | 4a. Facility Name (If not institution, give street and number) Stella Maris | | | | | | 4b. City, Town, or Location of Death Timonium | | | | 4c. County of Death Baltimore | | | | |
| Funeral Director | 5. Social Security Number 216-14-0497 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) July 2, 1922 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Parkton | | | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 10a. Street and Number 17505 Bushland Road | | | | | | 10f. Zip Code 21120 | | | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own Home | | | | | |
| 17. Father's Name (First, Middle, Last) Frank Davids | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Eva Hands | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Rodney D. Schmidt/Son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17505 Bushland Road Parkton, Maryland 21120 | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith | | | | Date 8/24/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Chronic Lung Disease</i> e. Due to (or as a consequence of): <i>Circumstances Lung</i> Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Aspirin overdose</i> <i>Respiratory failure</i> | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number 015504 | | 29d. Date signed (Month, Day, Year) 8-20-99 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. J. Sparks 2380 Pulney Valley Rd Balt. 21093 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | | | 32. Registrar's Signature | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

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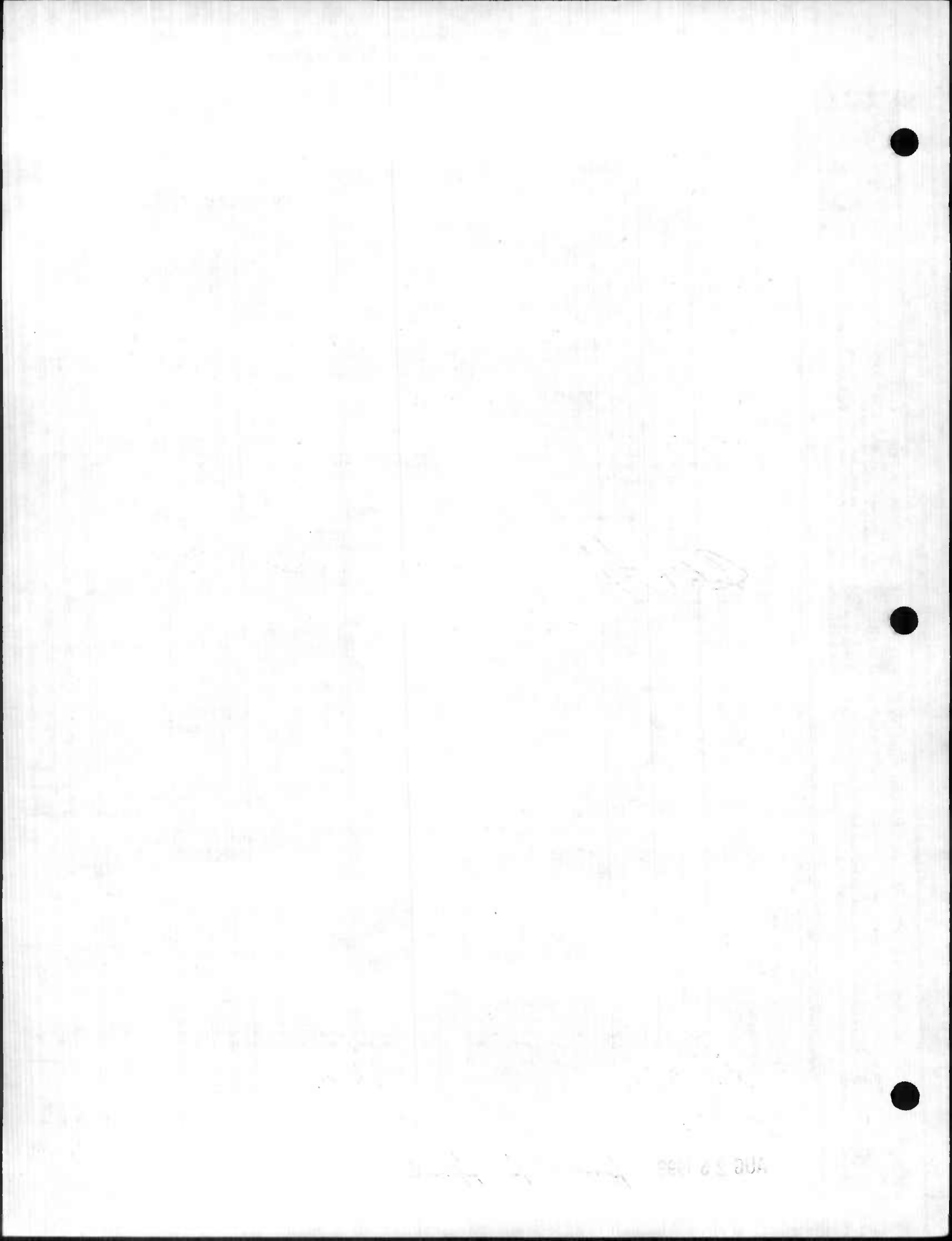
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Page 2 of 3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26670

| | | | | | | | | | | | |
|---|---|---------------------------------|---|---|--|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Arnetta Schneider</u> | | | | | 2. Date of Death Month <u>August</u> Day <u>22</u> Year <u>1999</u> | | 3. Time of Death <u>3:20 P</u> | | | |
| | 4a. Facility Name (If not institution, give street and number) <u>Johns Hopkins Bayview Hospital</u> | | | | | 4b. City, Town, or Location of Death <u>BALTIMORE</u> | | 4c. County of Death <u>N/A</u> | | | |
| Funeral Director | 5. Social Security Number <u>234-26-7417</u> | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>82</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>Sept 8, 1916</u> | | 9. Birthplace (State or Foreign Country) <u>WV</u> | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State <u>MD</u> | | 10b. County <u>Baltimore</u> | | 10c. City, Town or Location <u>Dundalk</u> | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10a. Street and Number <u>7403 School Ave</u> | | | | 10f. Zip Code <u>21222</u> | | | 10g. Citizen of What Country? <u>USA</u> | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u> | | | 16b. Kind of Business/Industry <u>Own Home</u> | | | | |
| 17. Father's Name (First, Middle, Last) <u>Fay E. Bonnell</u> | | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Malina Davis</u> | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Richard Schneider /son</u> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7403 School Ave Baltimore, MD 21222</u> | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Bel Air Memorial</u> | | | 20c. Location - City or Town, State <u>1999 Bel Air, MD</u> | | | | | |
| 21. Signature of Funeral Service Licensee <u>Anthony C. Connelly</u> | | | | | 22. Name and Address of Facility <u>Connelly Funeral Home of Dundalk</u> <u>7110 Sollers Point Rd 21222</u> | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death, do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ASPIRATION PNEUMONIA</u> Due to (or as a consequence of): b. <u>CVA</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death <u>DAYS</u> <u>YEARS</u> | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier <u>Ilene Browner</u> | | | | | 29c. License number <u>98021</u> | | 29d. Date signed (Month, Day, Year) <u>August 22 1999</u> | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Ilene Browner JHBM 4940 EASTERN AVE BALTIMORE, MD 21224</u> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>AUG 25 1999</u> | | | 32. Registrar's Signature <u>B. Sparks</u> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26671

| | | | | | | | | |
|--|--|--|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Sister Mary Ignatius Toodle, OSP | | | | 2. Date of Death Month 08 Day 21 Year 99 | | 3. Time of Death 9:15 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) Oblate Sisters of Providence (HCU) | | | | 4b. City, Town, or Location of Death Catonsville | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 220-58-1392 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) 08-21-09 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore (Catonsville) | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 701 Gun Road | | 10f. Zip Code 21227-3899 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: African-American | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Teacher | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School | | | | 16b. Kind of Business/Industry | | 17. Father's Name (First, Middle, Last) George Andrew Toodle | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Phyllis Ann Cooper | | | | 19a. Informant's Name/Relationship (Type, Print) Sister M. Alexis Fisher, OSP | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 Gun Road Baltimore, MD 21227-3899 | |
| Physician /Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | 20c. Location - City or Town, State 8-26-99 Baltimore, MD | | 21. Signature of Funeral Service Licensee  | |
| | 22. Name and Address of Facility March Funeral Home West 4300 Wabash Avenue | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. ACUTE MYOCARDIAL INFARCTION | | Approximate Interval Between Onset and Death INSTANT - NEQS | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Due to (or as a consequence of): | | c. Due to (or as a consequence of): | | d. Due to (or as a consequence of): | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 26. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 27. Date of Injury (Month, Day, Year) | | 27b. Time of Injury M | | 27c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury | | 28c. Injury at Work? | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Komal K. Dang | | |
| 29c. License number D18362 | | 29d. Date signed (Month, Day, Year) 8-25-99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOMAL K. DANG M.D. 3455 Wilkens Ave. Suite 308 Balto. Md 21229 | | 31. Date filed (Month, Day, Year) AUG 25 1999 | | |
| 32. Registrar's Signature  | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26672

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HORACE L. THOMPSON

2. Date of Death

August 21, 1999

3. Time of Death

10:15 PM

4a. Facility Name (If not institution, give street and number)

FAIRLAND ADVENTIST NURSING HOME

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

LAUREL

5. Social Security Number

257-28-0584

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 12, 1920

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5602 HARBOR VALLEY DR.

10f. Zip Code

21225

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
5th GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DRYWALL CONTRACTOR

16b. Kind of Business/Industry

SELF-EMPLOYED

17. Father's Name (First, Middle, Last)

JOHN H. THOMPSON

18. Mother's Name (First, Middle, Maiden Surname)

GEORGIE ISOM

19a. Informant's Name/Relationship (Type, Print)

MARTHA LOUISE THOMPSON (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5602 HARBOR VALLEY DRIVE, BALTIMORE, MD. 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

M.D. NATIONAL CEMETERY 8-28-99 LAUREL, MARYLAND

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John L. Hill

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE., BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CEREBROVASCULAR ACCIDENT

Approximate Interval Between Onset and Death

HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Luis A. Casas MD

29c. License number

D24997

29d. Date signed (Month, Day, Year)

8/23/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

LUIS A. CASAS MD 8312 CHERRY LANE LAUREL MD 20707

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26673

| | | | | | | | | | |
|---|--|--|----------------------------|---|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GEORGE TONGUE | | | | 2. Date of Death Month Day Year August 20, 1999 | | 3. Time of Death 19:30 | | |
| | 4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number UNKNOWN | | 6. Sex 10 M 20 F | 7. Age (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 04-09-18 | 9. Birthplace (State or Foreign) ANTIGUA WEST INDIES | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | 10d. Inside City Limits X Yes 2 No | | |
| 10e. Street and Number 5110 BELLEVILLE AVE | | | | 10f. Zip Code 21207 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status X Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LIVE STOCK | | | 16b. Kind of Business/Industry LABORER | | |
| 17. Father's Name (First, Middle, Last) SIDNEY TONGUE | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARY WILLIAMS | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) VERONICA REYNOLDS, NEICE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5110 BELLEVILLE AVE, BALTO. MD 21207 | | | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MOUNT ZION | | 20c. Location - City or Town, State 8-30-99 BALTIMORE, MD | | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Overwhelming sepsis Due to (or as a consequence of): b. Brain Lesion Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 24 hours | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? 1 Yes 2 No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | |
| 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) August 20, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uguchi Erondy, MD, Ph.D., Sinai Hospital, Baltimore, Maryland 21215 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

GEORGE A. TONGUE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26674

AMENDED ITEM #24a & #27 PER MD G774 8/25/99 AH

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|--|--|---|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DOROTHY WOOD | | | | 2. Date of Death Month August Day 7 Year 1999 | | 3. Time of Death 2:30 pm | | |
| | 4a. Facility Name (If not Institution, give street and number) 27067 Patriot Drive | | | | 4b. City, Town, or Location of Death Salisbury | | 4c. County of Death Wicomico | | |
| Funeral Director | 5. Social Security Number 476-07-3401 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) June 15, 1919 | | |
| | 9. Birthplace (State or Foreign Country) Minnesota | | 10a. State MD | | 10b. County Wicomico | | 10c. City, Town or Location Salisbury | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 27067 Patriot Drive | | 10f. Zip Code 21801 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | 16b. Kind of Business/Industry State Government | | | | | |
| 17. Father's Name (First, Middle, Last) Charles Milosevich | | | | 18. Mother's Name (First, Middle, Maiden Surname) Grace | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Jean Warren/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27067 Patriot Dr., Salisbury, MD 21801 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Data | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy board, 655 W. Baltimore St. Baltimore, MD 21201 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIOMYOPATHY Due to (or as a consequence of): ASHD Due to (or as a consequence of): HTN Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - ESRD - Hemodialysis - COPD | | | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Were an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 26. Place of Death (Check only one) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier [Signature] | | 29c. License number 53611 | | 29d. Date signed (Month, Day, Year) 8/11/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAZI S. KHAN 547-G RIVERSIDE DR SALISBURY, MD 21801 | | | | 31. Data filed (Month, Day, Year) AUG 25 1999 | | | | 32. Registrar's Signature [Signature] | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26675

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|--|---|---|--|--|-----------------------------------|---|----|-------------------------------------|---------|----------------------------------|--|--|----|------------|---------|----------------------------------|--|--|----|--|--|--|----------------------------------|--|--|--|----|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Spencer Wimple | | | | 2. Date of Death Month Day Year August 23 1999 | | 3. Time of Death 1024 PM | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Baltimore VA Medical Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 231-12-6262 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 2, 1918 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) North Carolina | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number 1334 N. Mount St. | | | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Afro-American | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Printer | | 16b. Kind of Business/Industry Printing Plant | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Willie Wimple | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Holloway | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Mary Wimple (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1334 N. Mount St. Balto. Md. 21217 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest | | 20c. Location - City or Town, State 8/30/99 Owings Mills, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee Joseph L. Russ | | | | 22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Acute Respiratory Distress Syndrome</td> <td>2 weeks</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Bronchitis</td> <td>3 weeks</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td colspan="2"></td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td colspan="2"></td> <td></td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Acute Respiratory Distress Syndrome | 2 weeks | Due to (or as a consequence of): | | | b. | Bronchitis | 3 weeks | Due to (or as a consequence of): | | | c. | | | | Due to (or as a consequence of): | | | | d. | | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Acute Respiratory Distress Syndrome | 2 weeks | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. | Bronchitis | 3 weeks | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary Fibrosis | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Harold Pierce MD | | 29c. License number P13404 | | 29d. Date signed (Month, Day, Year) August 23, 1999 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Harold Pierce, MD BVAMC 10 N. Greene St., Baltimore, MD 21209 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature Barbara G. Sparks | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26676

| | | | | | |
|--|--|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) FRANKLIN | | 2. Date of Death Month August Day 22 Year 1999 | | 3. Time of Death 10:40am |
| | 4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death NIA |
| Funeral Director | 5. Social Security Number 215-16-6747 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) AUG. 20, 1923 | | 9. Birthplace (State or Foreign Country) MARYLAND | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County NIA | | 10c. City, Town or Location BALTIMORE CITY |
| | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number 705 N. MILTON AVENUE | | 10f. Zip Code 21209 | | 10g. Citizen of What Country? USA. |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 6-11-47 2-15-49 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH GRADE College (1-4 or 5+) LABORER | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HARBORSON & WALKER | |
| 17. Father's Name (First, Middle, Last) EDWARD | | 18. Mother's Name (First, Middle, Maiden Surname) WARD | | 19. Informant's Name/Relationship (Type, Print) VANESSA WARD LUCAS (DAUGHTER) | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3617 EDMONDSON AVE., BALTIMORE, MD. 21229 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CROWNSVILLE CEMETERY | |
| 20c. Date 8-27-99 | | 20d. Location - City or Town, State CROWNSVILLE, MARYLAND | | 21. Signature of Funeral Service Licensee | |
| 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVENUE, BALTIMORE, MD. 21217 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. 30 yrs c. 30 yrs d. 30 yrs | | Approximate Interval Between Onset and Death 30 yrs | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insulin Dependent Diabetes Multiple Brain Stem Infarcts | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D 27315 | |
| 29d. Date signed (Month, Day, Year) August, 22, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M L Frydenborg St Agnes Hospital 1900 CATON AVENUE | | 31. Date filed (Month, Day, Year) AUG 25 1999 | |
| 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

NAME Franklin Ward

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26677

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 302-358-3000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

Physician /Medical Examiner

| | | | | | |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) LACY WALLACE | | 2. Date of Death Month AUGUST Day 20 , Year 1999 | | 3. Time of Death 1618 PM | |
| 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| 5. Social Security Number UNKNOWN | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 36 Yrs. | |
| 8. Date of Birth (Month, Day, Year) 01-15-62 | | 9. Birthplace (State or Foreign Country) BALTIMORE | | 10. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location BALTIMORE | |
| 10d. Street and Number 8510 GREENS LANE | | 10e. Zip Code 21244 | | 10f. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) TIRE REPAIR | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TIRE REPAIR SHOP | |
| 17. Father's Name (First, Middle, Last) WILSON WALLACE | | 18. Mother's Name (First, Middle, Maiden Surname) DAISY WALLACE | | 19. Informant's Name/Relationship (Type, Print) DAISY WALLACE, MOTHER | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS CEMETERY | | 20c. Date 8-28-99 | |
| 20d. Location - City or Town, State Arbutus, Maryland | | 21. Signature of Funeral Service Licensee <i>Willie E. Howard</i> | | 22. Name and Address of Facility Howell Funeral Home 4600 Liberty High, BALTO. UT | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. STARBUCKS OF CHEST | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 8-20-99 | | 28b. Time of Injury 1457P M | |
| 28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred SWING SET WAS STRUCK BY | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 4111 W. BELVEDERE AVE. BALTIMORE, MD | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Wayne Melkell</i> | | 29c. License number O.C.M.E. | |
| 29d. Date signed (Month, Day, Year) AUGUST 21, 1999 | | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) HARRY A. KOWAN 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year) AUG 25 1999 | |
| 32. Registrar's Signature <i>James B. Sparks</i> | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26678

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CLARENCE WILLIAMS | | | | 2. Date of Death Month AUGUST Day 22 Year 1999 | | 3. Time of Death 8:25 AM | |
| | 4a. Facility Name (If not institution, give street and number) GENESIS ELDERCARE KNOLLWOOD MANOR | | | | 4b. City, Town, or Location of Death MILLERSVILLE | | 4c. County of Death ANNE ARUNDEL CO. | |
| Funeral Director | 5. Social Security Number 212-10-9201 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth Month MARCH Day 11 Year 1919 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Pasadena | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 263 Maryland Ave. | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber | | 16b. Kind of Business/Industry Self Employed | | | |
| | 17. Father's Name (First, Middle, Last) William G. Williams, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sadie Schaffer | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Anna G. Williams Sister-In-Law | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 265 Maryland Ave. Pasadena, Maryland 21122 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Park Aug. 26, 1999 | | 20c. Location - City or Town, State Glen Burnie, Maryland | | | |
| | 21. Signature of Funeral Service Licensee Kevin E. Ecker | | 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Old cerebrovascular Accident | | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier Dr. O'Kane | | | | 29c. License number D-40521 | | 29d. Date signed (Month, Day, Year) August 24, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. O'KANE | | | | 7845 Oakwood Road Suite 205 Glen Burnie, MD 21061 | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AHY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26679

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ellen C. Yeager | | | | 2. Date of Death Month August Day 25 Year 1999 | | 3. Time of Death 7:05 AM | |
| | 4a. Facility Name (If not institution, give street and number) Harbour Hospital Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 220-05-0435 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 90 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov. 1, 1908 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Linthicum | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 306 Nancy Avenue | | | | 10f. Zip Code 21090 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | |
| 17. Father's Name (First, Middle, Last) James Edward Haupt | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Milholland | | | | |
| 19a. Informant's Name/Relationship (Type, Print) James Yeager (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1515 Marsha Road Baltimore, Maryland 21227 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | Date 8/28/99 | | 20c. Location - City or Town, State Baltimore, MD | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne, MD 21227 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Due to (or as a consequence of): b. Congestive Heart Failure Due to (or as a consequence of): c. Hypertention Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 5 Minutes 3 Months 30 Years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier  MD | | | | 29c. License number D 17743 | | 29d. Date signed (Month, Day, Year) August 25, 1999 | | |
| 30. Name and address of person who completed cause of death (item 23e) (Type, Print) L. Seenivasan, MD 606 Hammonds Lane Baltimore, Maryland 21225 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26680

| | | | | | | | | |
|--|---|--|---|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) VIRGINIA R YEAGER | | | | 2. Date of Death Month AUG Day 24 Year 1999 | | 3. Time of Death 11:50am | |
| | 4a. Facility Name (If not institution, give street and number) Hospice of Baltimore - Gilcrest | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 213-14-8696 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) June 24 1916 | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State Md | | 10b. County Baltimore | | 10c. City, Town or Location Essex | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 319 Stillwater Road | | 10f. Zip Code 21221 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry own home | | | |
| | 17. Father's Name (First, Middle, Last) Carlo D. Persgrhin | | | | 18. Mother's Name (First, Middle, Maiden Surname) Celide Rossi | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Ruth Franta / daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6428 Bricktown Circle Glen Burnie Md. 21061 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc. | | 20c. Date 8/25/99 | | 20d. Location - City or Town, State Baltimore Md. | |
| | 21. Signature of Funeral Service Licensee <i>R. Terry Connelly</i> | | | | 22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. melanoma | | | | Approximate Interval Between Onset and Death months | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| 29b. Signature and title of certifier <i>W. A. Riley, MD</i> | | | | 29c. License number 025205 | | 29d. Date signed (Month, Day, Year) August 24, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley 6800 N. Charles St. Balto. md 21208 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | |

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26681

| | | | | | | | | |
|---|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Pauline Sylvia Young | | | | 2. Date of Death Month Day Year August 24, 1999 | | 3. Time of Death 3:00a.m. | |
| | 4a. Facility Name (If not institution, give street and number) 2908 Edgecomb Circle South | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death n/a | |
| Funeral Director | 5. Social Security Number 218-28-8846 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) April 13, 1933 | |
| | 9. Birthplace (State or Foreign Country) Md. | | 10a. State Md. | | 10b. County n/a | | 10c. City, Town or Location Baltimore | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2908 Edgecomb Circle South | | 10f. Zip Code 21215 | | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (14 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk | | 16b. Kind of Business/Industry Social Security | | |
| 17. Father's Name (First, Middle, Last) Howard S. Dorsey | | | | 18. Mother's Name (First, Middle, Maiden Surname) Pauline Dickerson | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Charlotte V. Boyd Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3204 Elmora Avenue Baltimore, Md. 21213 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | 20c. Location - City or Town, State Baltimore, Md. | | 20d. Date Aug. 28 | | |
| 21. Signature of Funeral Service Licensee Ernest R. Ferry Jr. | | | | 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cor Pulmonale Due to (or as a consequence of): b. Chronic Obstructive Lung Disease Due to (or as a consequence of): c. Sleep Apnea Due to (or as a consequence of): d. | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Obesity | | | | | | | | |
| 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28g. | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Sheldon Goldberger M.D. | | | | 29c. License number D0 2392 | | 29d. Date signed (Month, Day, Year) 8/25/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sheldon Goldberger M.D. 1838 Green Tree Rd Pktnh MD 21208 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26682

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Dolores Elma Baldwin | | | | 2. Date of Death Month August Day 11 , Year 1999 | | 3. Time of Death 7:45 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 3205 Titan Terrace | | | | 4b. City, Town, or Location of Death Havre de Grace | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 217-20-2092 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) July 3, 1924 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Harford | | 10c. City, Town or Location Havre de Grace | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 3205 Titan Terrace | | 10f. Zip Code 21078 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry In home | | | | |
| 17. Father's Name (First, Middle, Last) William Wettig | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elma Courtney | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Benjamin F. Baldwin (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3205 Titan Terrace, Havre de Grace, MD 21078 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Memorial Gardens | | 20c. Location - City or Town, State 8/16/99 Aberdeen, Maryland | | | | |
| 21. Signature of Funeral Service Licensee <i>Kenneth B. Large</i> | | | | 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Breast Cancer | | | | Approximate Interval Between Onset and Death 11 YEARS | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>Edward M.D.</i> | | 29c. License number D 31775 | | |
| 29d. Date signed (Month, Day, Year) August 12, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John P. Edwards, M.D. | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 212 BELAIR ROAD AUSTON, MARYLAND 21047 | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1999 | | 32. Registrar's Signature <i>Benjamin B. Sparks</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26683

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Marie Brown

2. Date of Death

Month Day Year
August 10, 1999

3. Time of Death

03:50am

4a. Facility Name (If not institution, give street and number)

Continuum Care

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

5. Social Security Number

218-28-8633

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan 31, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7309 Second Avenue

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sale Clerk

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Hayden Sylvester Peregoy

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Marie Nebel

19a. Informant's Name/Relationship (Type, Print)

Mr. Ronald E. Brown (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3905 Walt-Ann Drive Ellicott City, MD 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

8/12/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Bria L. Haight

22. Name and Address of Facility

Haight Funeral Home & Chapel (Box 195)
Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Coronary Vascular Disease

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Mild - Intermittent Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert L. Moss, MD

29c. License number

032882

29d. Date signed (Month, Day, Year)

8/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert L. Moss 114 Business Center Drive Reisterstown, Md. 21136

State
Registrar

31. Date filed (Month, Day, Year)

AUG 11 1999

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26684

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Emily H. Bevard</i> | | | | 2. Date of Death Month <i>8</i> Day <i>8</i> Year <i>99</i> | | 3. Time of Death <i>11:05 AM</i> | | |
| | 4a. Facility Name (If not institution, give street and number) <i>Carroll Lutheran Village</i> | | | | 4b. City, Town, or Location of Death <i>Westminster</i> | | 4c. County of Death <i>Carroll</i> | | |
| Funeral Director | 5. Social Security Number <i>212-74-6912</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>95</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>Apr 10, 1904</i> | | |
| | 9. Birthplace (State or Foreign County) <i>Maryland</i> | | 10a. State <i>MD</i> | | 10b. County <i>Carroll</i> | | 10c. City, Town or Location <i>Westminster</i> | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number <i>300 St. Mark Way</i> | | 10f. Zip Code <i>21158</i> | | 10g. Citizen of What Country? <i>USA</i> | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i> | | 16b. Kind of Business/Industry <i>Domestic</i> | | 17. Father's Name (First, Middle, Last) <i>John Franklin Hanson</i> | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Anna Grace Smith</i> | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Mrs. Martha Streaker (Daughter)</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1150 West Friendship Road Sykesville, MD 21784</i> | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Wesley Chapel Cemetery</i> | | Date <i>8/11/99</i> | | 20c. Location - City or Town, State <i>Eldersburg, MD</i> | | | |
| 21. Signature of Funeral Service Licensee <i>Brian A. Haight</i> | | | | 22. Name and Address of Facility <i>Haight Funeral Home & Chapel (Box 195) Sykesville, MD 21784 (410)-795-1400</i> | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>CEREBROVASCULAR ACCIDENT</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death <i>46 days</i> | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CHRONIC LYMPHOCYTIC LEUKEMIA</i> <i>ADULT ONSET DIABETES MELLITUS</i> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>James H. Forsberg</i> | | 29c. License number <i>D33561</i> | |
| 29d. Date signed (Month, Day, Year) <i>08/09/99</i> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>James H. Forsberg, MD 912 Washington Rd. Westminster, MD 21157</i> | | 31. Date filed (Month, Day, Year) <i>AUG 11 1999</i> | | 32. Registrar's Signature <i>Beverly G. Sparks</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | |
|--|---|---|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARCUS JOSEPH BALES | | | | 2. Date of Death Month Day Year August 13, 1999 | | 3. Time of Death 11:30 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number) 12180 Popes Creek Road | | | | 4b. City, Town, or Location of Death Newburg | | 4c. County of Death Charles | | |
| Funeral Director | 5. Social Security Number 216-70-9176 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 42 Yrs. | 8. Date of Birth (Month, Day, Year) November 30, 1956 | | 9. Birthplace (State or Foreign Country) Virginia | | | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State MD | | 10b. County Charles | | 10c. City, Town or Location Port Tobacco | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 7720 Ann Harbor Drive | | | | 10f. Zip Code 20677 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter | | | 16b. Kind of Business/Industry Self-Employed | | |
| 17. Father's Name (First, Middle, Last) James Bales | | | | 18. Mother's Name (First, Middle, Maiden Surname) Nora Favier | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Paul Bales/Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13000 Sandwick Circle Ft. Washington, MD 20744 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Ignatius | | Date 8/19/99 | | 20c. Location - City or Town, State Port Tobacco, MD | | | |
| 21. Signature of Funeral Service Licensee David C. Echols M60945 | | | | 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME P.A. P.O. BOX 567 LA PLATA, MD 20646 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> a. NARCOTIC AND ALCOHOL INTOXICATION Due to (or as a consequence of): </div> <div style="width: 35%;"></div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 60%;"> b. Due to (or as a consequence of): </div> <div style="width: 35%;"></div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 60%;"> c. Due to (or as a consequence of): </div> <div style="width: 35%;"></div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 60%;"> d. Due to (or as a consequence of): </div> <div style="width: 35%;"></div> </div> | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 8-13-99 | | 28b. Time of Injury 10:30 A M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred SUBJECT INGESTED NARCOTIC AND ALCOHOL | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) PRIVATE DWELLING | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12180 POPES CREEK ROAD, NEWBURY, CHARLES COUNTY, MD. | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) August 14, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year) AUG 16 1999 | | 32. Registrar's Signature [Signature] | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26686

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) PATSY JEAN BOLYARD | | 2. Date of Death Month Day Year August 06 1999 | | 3. Time of Death 02:39 PM. | |
| 4a. Facility Name (If not institution, give street and number) Route 36 .6 mile south of Legislative Road | | | 4b. City, Town, or Location of Death Barton | | 4c. County of Death Allegany |
| 5. Social Security Number 236-78-5263 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 50 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 30, 1949 |
| 9. Birthplace (State or Foreign Country) West Virginia | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County Garrett | 10c. City, Town or Location Swanton | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 15944 Maryland Highway | | 10f. Zip Code 21561 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Licensed Practical Nurse | | 16b. Kind of Business/Industry Nursing Home | | | |
| 17. Father's Name (First, Middle, Last) Otis A. Metcalfe | | | 18. Mother's Name (First, Middle, Maiden Surname) Virginia M. Spitzer | | |
| 19a. Informant's Name/Relationship (Type, Print) L. Stanley Bolyard/Husband | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15944 Maryland Highway Swanton, MD 21561 | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Potomac Memorial Gardens | | 20c. Location - City or Town, State Keyser, WV | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 26726 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Scene | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) 8/6/99 | 28b. Time of Injury 2:30 PM | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred Driver of motor vehicle collides with another vehicle | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) Street; Rt. 36 Barton, Md. | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  Joseph Pestaner M.D. | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) August 7, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1999 | | 32. Registrar's Signature  | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26687

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|--|--|---|--|--------------------------------|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Donald M. Boggs | | | | 2. Date of Death Month August Day 13 Year 1999 | | | | 3. Time of Death 02:21 | |
| | 4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death CUMBERLAND | | | | 4c. County of Death ALLEGANY | |
| Funeral Director | 5. Social Security Number 219-14-7349 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 73 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) OCT 18 1925 | | 9. Birthplace (State or Foreign Country) MARYLAND | | Usual Residence of Decedent | | 10a. State MARYLAND | | 10b. County ALLEGANY | |
| To Be Completed by Funeral Director | 10c. City, Town or Location CUMBERLAND | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 12028 BEDFORD ROAD N.E. | |
| | 10f. Zip Code 21502 | | | | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| To Be Completed by Physician/Medical Examiner | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW11 | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MARYLAND DEPT. OF MOTOR VEHICLES LICENCE EXAMINER | | | | 16b. Kind of Business/Industry | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) JAMES BOGGS | | | | 18. Mother's Name (First, Middle, Maiden Surname) TACY ROBINETTE | | | | 19. Informant's Name/Relationship (Type, Print) NANCY POST DAUGHTER | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX # 669 CORNWALL NEW YORK 12518 | | | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) DAVIS MEMORIAL CEMETERY AUG 16 1999 CUMBERLAND MARYLAND | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RESPIRATORY FAILURE/ARREST | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE CONGESTIVE HEART FAILURE DIABETES ALCOHOL WITHDRAWAL SYNDROME - ACUTE | | | | 23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury M | |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and Title of Certifier  | | | | 29c. License number D33417 (MD) | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year) August 13, 1999 | | | | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) JAMES R. MOEN, M.D. 1068 NATIONAL HIGHWAY LAVALLE, MARYLAND 21502 | | | | 31. Date filed (Month, Day, Year) AUG 16 1999 | |
| | 32. Registrar's Signature  | | | | 33. State Registrar State Registrar | | | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 26688**
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---------------------------|--|---|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Orem Franklin Carroll | | | | 2. Date of Death Month Day Year August 10 1999 | | 3. Time of Death 0505 | |
| | 4a. Facility Name (If not institution, give street and number) Fallston General Hospital | | | | 4b. City, Town, or Location of Death Fallston | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 218-16-6526 | | 6. Sex XXM 2□ F | 7. Age (In yrs. last birthday) 77 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb. 27, 1922 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State MD | | 10b. County Harford | | 10c. City, Town or Location Aberdeen | | | 10d. Inside City Limits 1□ Yes 2□ No | |
| 10e. Street and Number 303 Graceford Drive | | | | 10f. Zip Code 21001 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1□ Never Married 2□ Married 3□ Widowed 4□ Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1□ Yes 2□ No If Yes, Give Year or Dates 1942-46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2□ No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Banker | | | 16b. Kind of Business/Industry Banking | |
| 17. Father's Name (First, Middle, Last) Charles F. Carroll | | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen Hummer | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Kellie C. Hallgren (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Fords Lane, Aberdeen, Maryland 21001 | | | | |
| 20a. Method of Disposition 1□ Burial 2□ Cremation 3□ Removal from State 4□ Donation 5□ Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baker Cemetery | | 20c. Location - City or Town, State 8/13/99 Aberdeen, Maryland | | |
| 21. Signature of Funeral Service Licensee Kirsten Amy Ungles | | | | 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 | | | | |
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Stroke Due to (or as a consequence of): b. Bacterial Endocarditis Due to (or as a consequence of): c. Gangrene + cellulitis of Left Foot Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate interval Between Onset and Death 5 days 2 weeks |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic valve replacement Diabetes mellitus | | | | | | 23b. Did tobacco use contribute to the cause of death? 1□ Yes 2□ No 3□ Probably 4□ Unknown | | |
| 25. Was case referred to medical examiner? 1□ Yes 2□ No | | | | | | 26. Place of Death (Check only one) Hospital: 1□ Inpatient 2□ ER/Outpatient 3□ DOA Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify) | | |
| 27. Manner of Death 1□ Natural 5□ Pending investigation 2□ Accident 6□ Could not be determined 3□ Suicide 4□ Homicide | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1□ Yes 2□ No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) 1□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier [Signature] MD | | 29c. License number 037517 | | 29d. Date signed (Month, Day, Year) August 10, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David C. Webb 104 plumtree Rd Bel Air MD 21015 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1999 | | 32. Registrar's Signature [Signature] | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26689

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|--|--|--|--|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Thomas Monroe Chaney | | | | 2. Date of Death Month Day Year August 8, 1999 | | 3. Time of Death 6:35 pm | | |
| | 4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital | | | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick | | |
| Funeral Director | 5. Social Security Number 212-20-6098 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 75 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Jan. 27, 1924 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Carroll | | 10c. City, Town or Location Union Bridge | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 421 Quaker Hill Rd. | | | | 10f. Zip Code 21791 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-45 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) administrator of operations | | | 16b. Kind of Business/Industry airplane mfg. | | |
| 17. Father's Name (First, Middle, Last) Thomas M. Chaney, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Betty Stull | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Walter Chaney/ cousin | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2500 Driftwood Ct. Frederick, MD 21702 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Prospect Cemetery | | Date 8/11/99 | | 20c. Location - City or Town, State Mt. Airy, MD | | | |
| 21. Signature of Funeral Service Licensee Catherine O. Dargatzis | | | | 22. Name and Address of Facility Hartzler Funeral Home 6 E. Broadway Union Bridge, MD 21791 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Pulmonary Edema Due to (or as a consequence of): ~17 days b. Acute Myocardial Infarction Due to (or as a consequence of): ~17 days c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial fibrillation Renal insufficiency Hypertension | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier Francis E. Becker MD | | | | 29c. License number D30496 MD | | 29d. Date signed (Month, Day, Year) 8/9/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Francis E. Becker MD, 300 W. 9th St, Frederick, MD 21701 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 10 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerPhysician
/Medical
Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26690

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)
SYDNEY LATIMER CARLISLE

2. Date of Death
Month: AUGUST Day: 9, Year: 1999

3. Time of Death
9:20AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)
Westminster Nursing & Rehab. Ctr.

4b. City, Town, or Location of Death
Westminster

4c. County of Death
Carroll

5. Social Security Number
213-05-9017

6. Sex
☒ M ☐ F

7. Age (In yrs. last birthday)
97 Yrs.

8. Date of Birth (Month, Day, Year)
May 14 1902

9. Birthplace (State or Foreign Country)
Maryland

Usual Residence of Decedent

10a. State
MD

10b. County
Carroll

10c. City, Town or Location
Hampstead

10d. Inside City Limits
☐ Yes ☒ No

10e. Street and Number
5109 A Blackrock Road

10f. Zip Code
21074

10g. Citizen of What Country?
USA

11. Marital Status
☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8 College (1-4 or 5+):

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Supervisor

16b. Kind of Business/Industry
Baltimore Transit System

17. Father's Name (First, Middle, Last)
Sydney Wallace Carlisle

18. Mother's Name (First, Middle, Maiden Surname)
Lily McLaughlin

19a. Informant's Name/Relationship (Type, Print)
Geneva V. Long - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5109 A Blackrock Rd., Hampstead, MD 21074

20a. Method of Disposition
☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery

20c. Location - City or Town, State
8-12-99 Woodlawn, MD

21. Signature of Funeral Service Licensee
[Signature]

22. Name and Address of Facility
Eline Funeral Home
934 S. Main St., Hampstead, MD 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. *Pneumonia*
Due to (or as a consequence of):

b. *Alzheimer's Dementia*
Due to (or as a consequence of):

c. *Congestive Heart Failure*
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?
☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
☐ Yes ☒ No

25. Was case referred to medical examiner?
☐ Yes ☒ No

28. Place of Death (Check only one)
Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death
☒ Natural ☐ Pending Investigation
☐ Accident ☐ Suicide ☐ Homicide
☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury
M

28c. Injury of Work?
☐ Yes ☒ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier
[Signature]

29c. License number
D38489

29d. Date signed (Month, Day, Year)
8/9/99

30. Name and address of person who completed cause of death item 23a) (Type, Print)
Peter Uggowitz
520 Black Rock Rd Hampstead, MD 21074

31. Date filed (Month, Day, Year)
AUG 10 1999

32. Registrar's Signature
[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

John H. ...

...



...

...

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26691

| | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ODESSA JEWELL CONRAD | | | | 2. Date of Death Month Day Year August 12, 1999 | | | | 3. Time of Death 0740 AM | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death CUMBERLAND | | | | 4c. County of Death ALLEGANY | | | | | | | |
| Funeral Director | 5. Social Security Number 214-07-2125 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) MAY 29 1917 | | 9. Birthplace (State or Foreign Country) W. VA. | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County ALLEGANY | | 10c. City, Town or Location CUMBERLAND | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| | 10e. Street and Number 209 DAVIDSON STREET | | | | 10f. Zip Code 21502 | | | | 10g. Citizen of What Country? U.S.A. | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOME MAKER | | | | 16b. Kind of Business/Industry HOME MAKER | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) CHARLES EDWARD JEWELL | | | | 18. Mother's Name (First, Middle, Maiden Surname) SARA CLINE | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) PAULMER CONRAD HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 DAVIDSON STREET CUMBERLAND MARYLAND 21502 | | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) LYBARGER CEMETERY AUGUST 14 1999 | | | | 20c. Location - City or Town, State MADLEY, PA. | | | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Dale L. Merritt</i> | | | | 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND | | | | | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| | Immediate Cause (Final disease or condition resulting in death) e. <u>CARDIOGENIC SHOCK</u> Due to (or as a consequence of): | | | | | | | | | | | | TWO DAYS | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. <u>MYOCARDIAL ISCHEMIA</u> Due to (or as a consequence of): | | | | | | | | | | | | TWO DAYS | | | |
| | c. <u>CORONARY ARTERY DISEASE</u> Due to (or as a consequence of): | | | | | | | | | | | | TEN YEARS | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DIABETES</u> | | | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | 29c. License number 033417 | | 29d. Date signed (Month, Day, Year) August 12, 1999 | |
| | 29b. Signature and title of certifier <i>[Signature]</i> | | | | | | | | | | | | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES R MOEN, MD 1063 NATIONAL HIGHWAY LAVALLE, MD 21502 | | | | | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 13 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

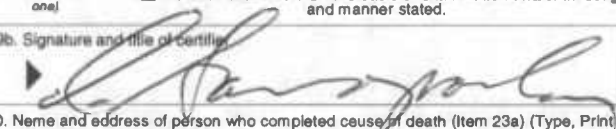
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26692

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) RUTH AVERAL CAMPBELL | | | | | | 2. Date of Death Month Day Year AUGUST 3, 1999 | | | 3. Time of Death 6:40 PM | |
| | 4a. Facility Name (If not institution, give street and number) 114 JASPER RILEY ROAD | | | | | | 4b. City, Town, or Location of Death OAKLAND | | | 4c. County of Death GARRETT | |
| Funeral Director | 5. Social Security Number 212-24-1074 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) OCT 5, 1923 | | 9. Birthplace (State or Foreign Country) MARYLAND | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County GARRETT | | 10c. City, Town or Location OAKLAND | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 114 JASPER RILEY ROAD | | | | | | 10f. Zip Code 21550 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | | 16b. Kind of Business/Industry OWN HOME | | | | |
| 17. Father's Name (First, Middle, Last) OWEN U. MARTIN | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) LEOLA SCHLOSSNAGLE | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) WALTER CAMPBELL - HUSBAND | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 JASPER RILEY ROAD OAKLAND, MD 21550 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) PLEASANT VALLEY CEMETERY | | Date 8/6/99 | | 20c. Location - City or Town, State OAKLAND, MARYLAND | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ovarian CA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death > 8 yrs | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | | | | 28d. Describe how Injury occurred | | | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | | 29c. License number D42646 | | 29d. Date signed (Month, Day, Year) August 6, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. SAVOPOULOS, M.D. RT. 1 BOX 5A-1 TERRA ALTA, WV 26764 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG - 9 1999 | | | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

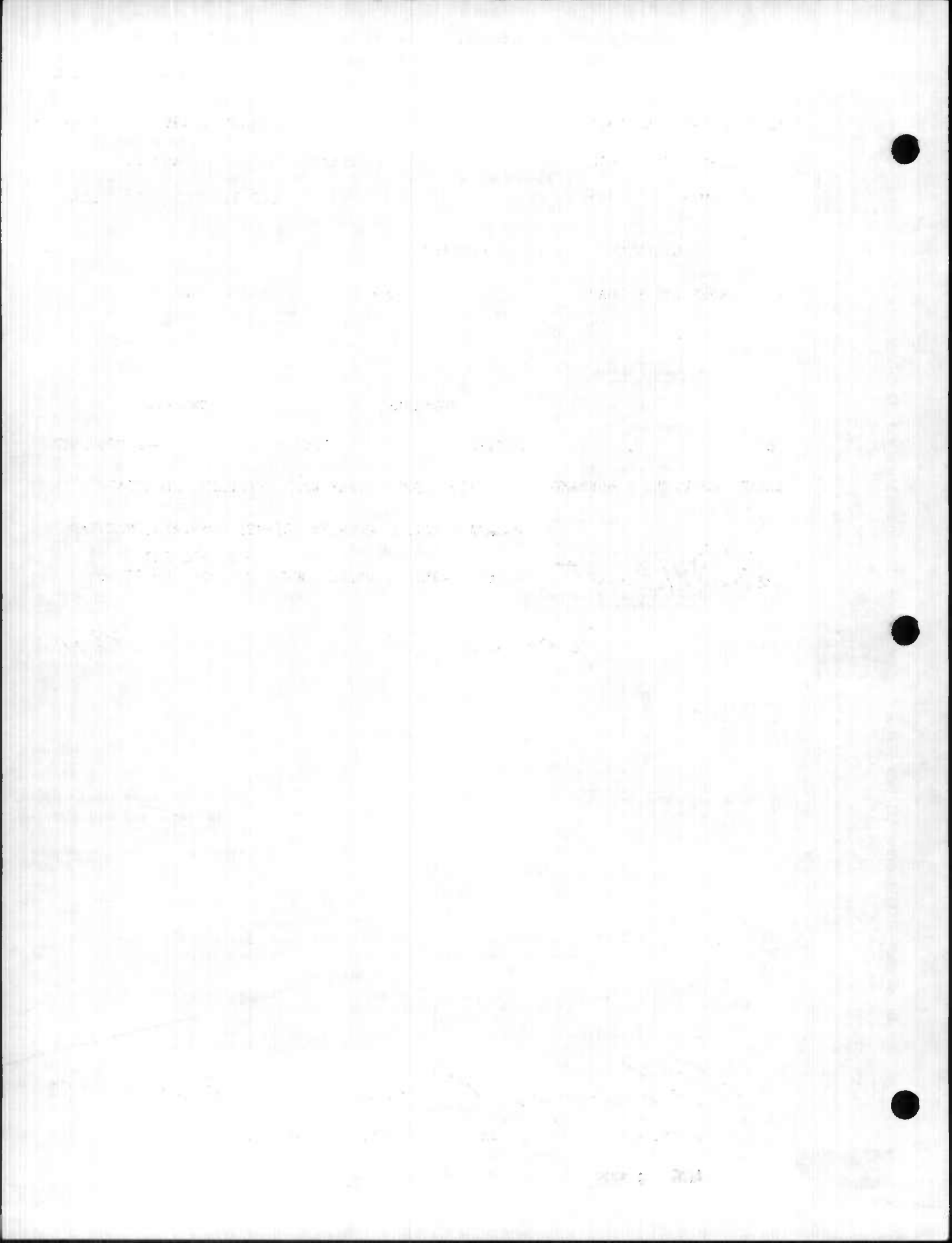
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26693

| | | | | | | | | | | |
|--|--|---------------------------------|---|--|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Norma Elizabeth Davis | | | | | | 2. Date of Death Month Day Year AUGUST 3, 1999 | | 3. Time of Death 5:15 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital | | | | | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany | |
| Funeral Director | 5. Social Security Number 232-26-3852 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 28, 1923 | | 9. Birthplace (State or Foreign Country) West Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State WV | | 10b. County Hampshire | | 10c. City, Town or Location Romney | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 306 School Street | | | | 10f. Zip Code 26757 | | 10g. Citizen of What Country? United States | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager | | | 16b. Kind of Business/Industry Banking | | | |
| 17. Father's Name (First, Middle, Last) Wesley Talmadge Smith | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Iva Agnes Rogers | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Karen E. Osentoski | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2 Box 391, Keameysville, WV 25430 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ebenezer Cemetery | | | Date 08-07-99 | | 20c. Location - City or Town, State Romney, WV | | |
| 21. Signature of Funeral Service Licensee WV Funeral Director #1320 WV Embalmers #1620 <i>W. Page Baldwin</i> | | | | | | 22. Name and Address of Facility Baldwin Funeral Home, Inc. P.O. Box 1940, Romney, WV 26757 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE MYELOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Approximate Interval Between Onset and Death 4 MONTHS | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>John</i> Physician | | | | | | 29c. License number D50844 | | 29d. Date signed (Month, Day, Year) AUGUST 5, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSE LOVERA JR., MD 912 STON DRIVE CUMBERLAND MD 21512 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | | | | | 32. Registrar's Signature <i>B. Apone</i> | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-386-0000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5

THD

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VW year: 88-TO-90 y (date): 10/20/2000 y (date): 10/20/2000

9-12, Box 1940, Denver, CO 80202
 (303) 733-1111

1

Amended # 10c, nhs
8/10/99, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26694

| | | | | | | | | |
|---|--|--|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) FRANK WILLETT'S DUNCAN, JR. | | | | 2. Date of Death Month Day Year AUGUST 5 1999 | | 3. Time of Death 1400 | |
| | 4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death CUMBERLAND | | 4c. County of Death ALLEGANY | |
| Funeral Director | 5. Social Security Number 220 30 8178 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 | | 8. Date of Birth (Month, Day, Year) JULY 30 1933 | |
| | 9. Birthplace (State or Foreign Country) FROSTBURG | | 10a. State MARYLAND | | 10b. County ALLEGANY | | 10c. City, Town or Location 152 CENTER STREET Frostburg | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 152 CENTER STREET | | 10f. Zip Code 21532 | | |
| 10g. Citizen of What Country? U.S. | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: KOREAN CONFLICT | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) BARTENDER | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AMERICAN LEGION | | 16b. Kind of Business/Industry | | |
| 17. Father's Name (First, Middle, Last) FRANK DUNCAN | | 18. Mother's Name (First, Middle, Maiden Surname) NOVELLA STEVENSON | | 19a. Informant's Name/Relationship (Type, Print) MAUREEN DUNCAN / WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 152 CENTER ST., FROSTBURG, MD 21532 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) FROSTBURG MEMORIAL PARK | | 20c. Date 8/7/99 | | 20d. Location - City or Town, State FROSTBURG, MD | | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METASTATIC BRAIN DISEASE | | Approximate Interval Between Onset and Death 1 month | | |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D21244 | | 29d. Date signed (Month, Day, Year) AUGUST 6 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus Tan, M.D. Frostburg Plaza Frostburg, MD 21532 | | 31. Date filed (Month, Day, Year) AUG 10 1999 | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26695

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) VIOLET ELMYRA DeVELBISS | | | | 2. Date of Death Month Day Year AUGUST 12, 1999 | | 3. Time of Death 1410 PM | |
| | 4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death CUMBERLAND | | 4c. County of Death ALLEGANY | |
| Funeral Director | 5. Social Security Number 214-46-3257 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) NOV 26 1919 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State W.VA. | | 10b. County MINERAL | | 10c. City, Town or Location RIDGELEY | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number RFD# 1 BOX# 156 (WILEY FORD) | | 10f. Zip Code 26753 | |
| | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRINCE WILLIAM CO. VIRGINIA | | | | 16b. Kind of Business/Industry CLERK | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) HARRY B. ELLIFRITZ | | | | 18. Mother's Name (First, Middle, Maiden Surname) HAZEL TASKER | | | |
| | 19a. Informant's Name/Relationship (Type, Print) CURTIS VANCE DeVELBISS HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RFD#1 BOX#156 RIDGELEY, WEST VIRGINIA 26753 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) POTOMAC MEMORIAL GARDENS | | 20c. Location - City or Town, State AUG 14 1999 KEYSER, W.VA. | |
| | 21. Signature of Funeral Service Licensee Dale L. Menitt | | | | 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary edema Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death 5 days | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier G. Wagoner | | | | 29c. License number D22181 | | 29d. Date signed (Month, Day, Year) AUGUST 13, 1999 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR GARY L. WAGONER 925 BISHOP WALSH DRIVE CUMBERLAND MARYLAND 21502 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 13 1999 | | | | 32. Registrar's Signature B. Sparks | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26696
Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|--|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ELIZABETH SOPHIA DAVIS | | | | 2. Date of Death Month Day Year AUGUST 12, 1999 | | 3. Time of Death 1315 | | |
| | 4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death CUMBERLAND | | 4c. County of Death ALLEGANY | | |
| Funeral Director | 5. Social Security Number 453-05-8376 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 89 Yrs. | | 8. Date of Birth (Month, Day, Year) JUNE 18, 1910 | | |
| | 9. Birthplace (State or Foreign Country) NEW MEXICO | | 10a. State MD | | 10b. County ALLEGANY | | 10c. City, Town or Location CUMBERLAND | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 14503 N. BEL AIR DRIVE, S.W. | | 10f. Zip Code 21502 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry HOME | | 17. Father's Name (First, Middle, Last) FRED SCHULLER | | 18. Mother's Name (First, Middle, Maiden Surname) KATHERINE ODOR | |
| 19a. Informant's Name/Relationship (Type, Print) KATHRYN BROWN / SISTER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14503 n. bel air drive, s.w.-CUMBERLAND, MD 21502 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ST. AMBROSE CEMETERY | | 20c. Location - City or Town, State 8/16/99 CUMBERLAND, MD | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) s. MYOCARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death MONTHS | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number 057931 | | 29d. Date signed (Month, Day, Year) AUGUST 13, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIRGINIA E. MARGOLIS, MD 912 WATSON DRIVE CUMBERLAND, MD 21502 | | 31. Date filed (Month, Day, Year) AUG 16 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26697

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Elmer Eugene Fike | | 2. Date of Death Month Day Year August 11 1999 | | 3. Time of Death 09:15 AM. | |
| 4a. Facility Name (If not institution, give street and number) 502 East High Street | | 4b. City, Town, or Location of Death Oakland | | 4c. County of Death Garrett | |
| 5. Social Security Number 214-32-3739 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 63 Yrs. | |
| 8. Date of Birth (Month, Day, Year) Sept. 27, 1935 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| 10a. State MD | | 10b. County Garrett | | 10c. City, Town or Location Oakland | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 4 S. Fourth Street | | 10f. Zip Code 21550 | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (14 or 5+) College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | 16b. Kind of Business/Industry Manufacturing | |
| 17. Father's Name (First, Middle, Last) Walter Gordon Fike | | 18. Mother's Name (First, Middle, Maiden Surname) Nora Frances Knox | | | |
| 19a. Informant's Name/Relationship (Type, Print) Tammy Welling/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5362 Hutton Road, Oakland, Md. 21550 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Deep Creek Baptist Cem. | | 20c. Location - City or Town, State McHenry, Maryland | |
| 20d. Date 8/14/99 | | | | | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hanging Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Scene | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) UNK | | 28b. Time of Injury UNK M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject hanged self | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) Oakland Cemetery, Oakland, Maryland | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  | | 29b. Signature and title of certifier O.C.M.E. | | 29c. License number O.C.M.E. | |
| 29d. Date signed (Month, Day, Year) August 12, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Aaron Lake, 12 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 13 1999 | | 32. Registrar's Signature  | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26698

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) VERA C. GRAHAM | | | | 2. Date of Death Month AUGUST Day 8 Year 1999 | | 3. Time of Death 8:50 AM | |
| 4a. Facility Name (If not institution, give street and number) CUMBERLAND VILLA NURSING CENTER | | | | 4b. City, Town, or Location of Death CUMBERLAND | | 4c. County of Death ALLEGANY | |
| 5. Social Security Number 213-50-1012 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 86 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) AUG. 30, 1912 | |
| 9. Birthplace (State or Foreign Country) PENNSYLVANIA | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County ALLEGANY | | 10c. City, Town or Location CUMBERLAND | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 235 PACA STREET | | | | 10f. Zip Code 21502 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry HOME | |
| 17. Father's Name (First, Middle, Last) SAMUEL MARTIN MAUK | | | | 18. Mother's Name (First, Middle, Maiden Surname) REBECCA BARNETT | | | |
| 19a. Informant's Name/Relationship (Type, Print) JOSEPH GRAHAM / SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15207 TRAILRIDGE RD., CUMBERLAND, MD 21502 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ZION MEMORIAL PARK | | Date 8/11/99 | | 20c. Location - City or Town, State CUMBERLAND, MD | |
| 21. Signature of Funeral Service Licensee <i>Steady D. Lockman</i> | | | | 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 15 years | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number D36766 | | 29d. Date signed (Month, Day, Year) AUGUST 11, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) VIK POONAI, M.D. - 920 NATIONAL HIGHWAY, LAVALLE, MD 21502 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | |

State
Registrar

Charles H. Johnson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26699

| | | | | | | | | |
|--|--|--|--|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Vincent Santo Guido | | | | 2. Date of Death Month Day Year August 11, 1999 | | 3. Time of Death 0410 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital | | | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany | |
| Funeral Director | 5. Social Security Number 216-18-1646 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov 1, 1921 | |
| | 9. Birthplace (State or Foreign Country) Italy | | 10a. State MD | | 10b. County Allegany | | 10c. City, Town or Location Cumberland | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 12 Smith Street | | 10f. Zip Code 21502 | | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) 12 Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired | | 16b. Kind of Business/Industry Tire Company | | |
| 17. Father's Name (First, Middle, Last) Frank M. Guido | | | | 18. Mother's Name (First, Middle, Maiden Surname) Angelina (LaNeve) | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Margaret Guido wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Smith Street; Cumberland MD 21502 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Patrick's Cemetery | | | | |
| 20c. Date 8/13/ | | | | 20d. Location - City or Town, State Cumberland, MD | | | | |
| 21. Signature of Funeral Service Licensee Nicholas J. Scarpelli | | | | 22. Name and Address of Facility Scarpelli Funeral Home P.A. Cumberland, Maryland 21502 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC LUNG ADENOCARCINOMA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | |
| Approximate Interval Between Onset and Death 6 MONTHS | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and Title of certifier Physician | | | | 29c. License number D50844 | | 29d. Date signed (Month, Day, Year) August 11, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSE LOVERIA, M.D. 912 SETON DRIVE CUMBERLAND, MD 21502 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1999 | | | | 32. Registrar's Signature B. Sparks | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26700

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH M

2. Date of Death

Month

Day

Year

August 8, 1999

3. Time of Death

1:08 P

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL BALTIMORE CITY

4b. City, Town, or Location of Death

4c. County of Death

Funeral
Director

5. Social Security Number

215-25-9930

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

9

Yrs.

8. Date of Birth

Aug. 22, 1989

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Eldersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

886 Johnsville Road

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
4

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Student

16b. Kind of Business/Industry

Elementary

17. Father's Name (First, Middle, Last)

Joseph Hegarty

18. Mother's Name (First, Middle, Maiden Surname)

Lisa Ann Bausman

19a. Informant's Name/Relationship (Type, Print)

Mr. & Mrs. Joseph Hegarty (parents)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

886 Johnsville Road Eldersburg, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Crestlawn Mem. Gardens

Date

8/12/99

20c. Location - City or Town, State

Marriottsville, MD

21. Signature of Funeral Service Licensee

Brian L. Haight

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL (Box 195)
Sykesville, MD 21784 (410)-795-140023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Intracranial Hemorrhage 2 DAYS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. MULTISYSTEM ORGAN FAILURE 2 WEEKS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

WYNNE MORRISON MD

29c. License number

DS3215

29d. Date signed (Month, Day, Year)

August 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WYNNE MORRISON

600 N. WOLFEST BALTIMORE, MD 21287

JOHNS HOPKINS HOSPITAL

31. Date filed (Month, Day, Year)

AUG 11 1999

32. Registrar's Signature

P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

15. 11. 1944. (1944. 11. 15.)

1. 11. 1944. (1944. 11. 1.)

2. 11. 1944. (1944. 11. 2.)

3. 11. 1944. (1944. 11. 3.)

4. 11. 1944. (1944. 11. 4.)

5. 11. 1944. (1944. 11. 5.)

6. 11. 1944. (1944. 11. 6.)

7. 11. 1944. (1944. 11. 7.)

8. 11. 1944. (1944. 11. 8.)

9. 11. 1944. (1944. 11. 9.)

10. 11. 1944. (1944. 11. 10.)

11. 11. 1944. (1944. 11. 11.)

12. 11. 1944. (1944. 11. 12.)

13. 11. 1944. (1944. 11. 13.)

14. 11. 1944. (1944. 11. 14.)

15. 11. 1944. (1944. 11. 15.)

16. 11. 1944. (1944. 11. 16.)

17. 11. 1944. (1944. 11. 17.)

18. 11. 1944. (1944. 11. 18.)

19. 11. 1944. (1944. 11. 19.)

20. 11. 1944. (1944. 11. 20.)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26701

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Elwood Hughes, Jr.

2. Date of Death

August 10 1999

3. Time of Death

1334

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

214-30-8625

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr 28 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Toddville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2531 Toddville Rd.

10f. Zip Code

21672

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1954-56

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

machine operator

16b. Kind of Business/Industry

wire belt mfg.

17. Father's Name (First, Middle, Last)

James Elwood Hughes

18. Mother's Name (First, Middle, Maiden Surname)

Zenita Phillips

19a. Informant's Name/Relationship (Type, Print)

Mrs. Sue Hughes - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2531 Toddville Rd. Toddville MD 21672

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dorchester memorial Park

Date

8-13-99

20c. Location - City or Town, State

Cambridge Maryland

21. Signature of Funeral Service Licensee

Kenneth R. Thomas Jr.

22. Name and Address of Facility

Thomas Funeral Home PA

700 Locust St. Cambridge MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Cardiogenic shock.

Due to (or as a consequence of):

Acute MI

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. coronary atherosclerosis.

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hyperlipidemia.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. G.

29c. License number

D 25036

29d. Date signed (Month, Day, Year)

8/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D H. R. HEDA. 614 D Ewsteeen shaw Drive SALISBURY, MD

State
Registrar

31. Date filed (Month, Day, Year)

AUG 12 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020 EdB
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26702

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|---|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary Cornelia Jackson | | | | 2. Date of Death Month Day Year Aug. 1, 1999 | | 3. Time of Death 11:00 PM | |
| | 4a. Facility Name (If not institution, give street and number) Blue Point Rehab. Center | | | | 4b. City, Town, or Location of Death Balto. City | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 215-28-8151 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 99 Yrs. | If Under 1 Year Month Days | If Under 24 Hrs. Hours Min. | 6. Date of Birth (Month, Day, Year) 8/16/1899 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD. | 10b. County Balto. Co. | 10c. City, Town or Location 2314 Corbert Rd. Monkton, Md. | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 2314 Corbert Road | | | 10f. Zip Code 21111 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook | | 18b. Kind of Business/Industry Schools | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Garfield Walton | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Roberta Davis | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Gladys M. Robinson daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2314 Corbert Rd. Monkton, Md. 21111 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Union Chapel Cem. | | Date 8/5/99 | | 20c. Location - City or Town, State Monkton, MD. | |
| | 21. Signature of Funeral Service Licensee <i>Benjamin W. Kurtz</i> | | | 22. Name and Address of Facility Jarrettsville, Md. 21084 Kurtz Funeral Home, P.A. P.O. Box 6 | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dementia Due to (or as a consequence of): ASCVD | | | | | | | Approximate Interval Between Onset and Death |
| | b. Due to (or as a consequence of): | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | |
| | d. Due to (or as a consequence of): | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier <i>Deborah Marie MD</i> | | | | 29c. License number A31364 | | 29d. Date signed (Month, Day, Year) 8/5/99 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 Crossroads Dr. #250 Owings Mills, MD 21117 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 12 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26703

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|---|---|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edna F. Judy | | | | 2. Date of Death Month Aug Day 8 Year 1999 | | 3. Time of Death 10:57pm | | |
| | 4a. Facility Name (If not institution, give street and number) 13507 Winter Lane | | | | 4b. City, Town, or Location of Death Cresaptown | | 4c. County of Death Allegany | | |
| Funeral Director | 5. Social Security Number 216-22-6894 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 90 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb 4, 1909 | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State MD | | 10b. County Allegany | | 10c. City, Town or Location Cresaptown | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 13507 Winter Lane | | | | 10f. Zip Code 21502 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) Wrussell Winter | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary (Grabenstein) | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Donald E. Lafferty | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2409 Cypress Lake Rd; Hope Mills, NC 28348 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Restlawn Memorial Gard | | 20c. Location - City or Town, State 8/11/ LaVale, MD | | | |
| 21. Signature of Funeral Service Licensee <i>Richard J. Scarpelli</i> | | | | 22. Name and Address of Facility Scarpelli Funeral Home P.A. Cumberland, Maryland 21502 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Heart Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death unknown | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <i>Paul Snow</i> | | 29c. License number D09157 | | 29d. Date signed (Month, Day, Year) Aug 8, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Snow M.D. 124 W. 3rd Street Cumberland MD 21502 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26704

| | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Scott Keiling | | | | | | 2. Date of Death Month Day Year AUGUST 9 1999 | | 3. Time of Death 6:40 AM | |
| | 4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital | | | | | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany | |
| Funeral Director | 5. Social Security Number 577-07-4878 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) 08-Mar-07 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Allegany | | 10c. City, Town or Location Frostburg | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 11110 Welsh Hill Road | | | | 10f. Zip Code 21532- | | | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Vice-President | | | | 16b. Kind of Business/Industry Insurance company | | |
| 17. Father's Name (First, Middle, Last) John S. Keilling, Sr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Isabella Dudley | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary Keiling Wife | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11110 Welsh Hill Road Frostburg Maryland 21532- | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Frostburg Memorial Park | | 20c. Location - City or Town, State 12-Aug-99 Frostburg, Maryland | | | | |
| 21. Signature of Funeral Service Licensee  | | | | | | 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Renal Failure Due to (or as a consequence of): b. Nephrosclerosis Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 23 days 10 years 30 years | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Septicemia, Pancreatitis, acute cholecystitis Pneumonia - Congestive heart Failure. Chronic Obstructive Pulmonary Disease | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number D 14464 | | 29d. Date signed (Month, Day, Year) AUGUST 9, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sikander Sandhir M.D. 48 Tarn Terrace Frostburg MD 21532 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26705

| | | | | | | | | | | |
|--|---|--|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROSE LEE KLOTER | | | | 2. Date of Death Month Day Year AUGUST 10 1999 | | | | 3. Time of Death 6:45 AM | |
| | 4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital | | | | 4b. City, Town, or Location of Death Cumberland | | | | 4c. County of Death Allegany | |
| Funeral Director | 5. Social Security Number 215-42-4845 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 23, 1918 | | 9. Birthplace (State or Foreign Country) West Virginia | |
| | Usual Residence of Decedent | | | | 10a. State WV | | 10b. County Mineral | | 10c. City, Town or Location Keyser | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 12 North Main Street, Apt. 402 | | | | 10f. Zip Code 26726 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nursing Assistant | | | | 16b. Kind of Business/Industry Hospital | | | | 17. Father's Name (First, Middle, Last) Homer E. Beavers | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Florence L. Paugh | | | | 19a. Informant's Name/Relationship (Type, Print) Doris Kokta/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7750 Rossville Blvd. Baltimore, MD 21236 | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bloomington Cemetery | | | | 20c. Location - City or Town, State Bloomington, MD | |
| | 21. Signature of Funeral Service Licensee <i>Brian L. Smith</i> | | | | 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 26726 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cerebro-vascular accident</i> Due to (or as a consequence of): b. <i>Cerebral edema</i> Due to (or as a consequence of): c. <i>Hypertension</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i> | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) Aug 10 1999 | | | | 28b. Time of Injury M | |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>Mohammad Shafiei, MD</i> | | |
| 29c. License number D 28932 | | | | 29d. Date signed (Month, Day, Year) AUGUST 12 1999 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammad Shafiei, M.D. 902 Seton DR. CUMBERLAND, MD 21502 | | |
| 31. Date filed (Month, Day, Year) AUG 16 1999 | | | | 32. Registrar's Signature <i>Barbara B. [Signature]</i> | | | | State Registrar | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

CJ
Victoria Sue
Kerr

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26706

| | | | | | | | | |
|---|--|---|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Victoria Susan Kerr | | | | 2. Date of Death Month Day Year August 13 1999 | | 3. Time of Death 03:32 AM. | |
| | 4a. Facility Name (If not institution, give street and number) 128 Arch Street | | | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany | |
| Funeral Director | 5. Social Security Number 214-02-1342 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 35 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb 27, 1964 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County Allegany | | 10c. City, Town or Location Cumberland | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 128 Arch Street | | 10f. Zip Code 21502 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) certified care giver | | 16b. Kind of Business/Industry New Life Shelter | | | | |
| 17. Father's Name (First, Middle, Last) Glenn D. Kerr | | | | 18. Mother's Name (First, Middle, Maiden Surname) Dorothy L (Dawson) | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Dorothy L. Kerr mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 514 Rose Hill Avenue; Cumberland MD 21502 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Par8/17/ Cumberland, MD | | 20c. Location - City or Town, State | | | | |
| 21. Signature of Funeral Service Licensee Michael C. Stotter | | 22. Name and Address of Facility Scarpelli Funeral Home P.A. Cumberland, Maryland 21502 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Intra-oral gunshot wound Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| | | | | 24a. Was an autopsy performed? Limited 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 8-12-99 | | 28b. Time of Injury unknown | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred subject shot self | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 128 Arch Street Allegany County, Maryland | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Stephen S. Radentz, M.D. | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) August 13, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 16 1999 | | 32. Registrar's Signature Benita B. [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26707

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Helen Katherine Kalbaugh | | | | | | 2. Date of Death Month 08 Day 02 Year 99 | | 3. Time of Death 10:00 p.m. | | |
| | 4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital | | | | | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany | | |
| Funeral Director | 5. Social Security Number 217-05-0389 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 11, 1915 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | 10a. State Md | | 10b. County Allegany | | 10c. City, Town or Location Westernport |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 10e. Street and Number 25701 Shady Lane, SW | | 10f. Zip Code 21562 | | 10g. Citizen of What Country? United States |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Home | | | | |
| | 17. Father's Name (First, Middle, Last) Willis B. McCombs | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Moran | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Helen Scott / Niece | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt 1 Box 6 N Huttonville, Ill 62433 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Philos Cemetery | | | Date 8/5/99 | | 20c. Location - City or Town, State Westernport, Md | | |
| | 21. Signature of Funeral Service Licensee Wayne Bul | | | | 22. Name and Address of Facility Boal Funeral Home | | 111 Church St. Westernport, MD 21562 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Dysrhythmia Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death 30 minutes |
| | Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dehydration; Septic Syndrome; anemia; Coronary artery Disease; History of myocardial infarction in the past; History of Gastric Adenocarcinoma; cerebrovascular accident Due to (or as a consequence of): | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration; Septic Syndrome; anemia; Coronary artery Disease; History of myocardial infarction in the past; History of Gastric Adenocarcinoma; cerebrovascular accident | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier Jesus Tan | | | | | | 29c. License number D21244 | | 29d. Date signed (Month, Day, Year) August 3, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus Tan Rt 36 Frostburg Plaza, Frostburg MD 21532 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG - 5 1999 | | | | | | 32. Registrar's Signature B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26708

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THEODORE MILTON KAY, JR.

2. Date of Death

Month Day Year
August 10 1999

3. Time of Death

6:10pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

5. Social Security Number

579-68-9531

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC. 29, 1952

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

WALDORF

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

315 GARNER AVENUE

10f. Zip Code

20602

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1971
1972

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OWNER/OPERATOR

16b. Kind of Business/Industry

ROOFING

17. Father's Name (First, Middle, Last)

THEODORE MILTON KAY, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MARILYN TURNER

19a. Informant's Name/Relationship (Type, Print)

MRS. JOSEPHINE KAY - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

315 GARNER AVENUE, WALDORF, MD 20602

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

TRINITY MEM. GARDENS, AUGUST 14, 1999, WALDORF, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

MGB
MARK G. BROHAWN MO0053

22. Name and Address of Facility

THE HUNTT FUNERAL HOME, INC.
P.O. BOX 156, WALDORF, MARYLAND 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cardiopulmonary arrest*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Aspiration pneumonia*
Due to (or as a consequence of):

30 min

c. *Carcinoma of Gastro esophageal junction*
Due to (or as a consequence of):

4 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Signature: [Signature]

29c. License number

D - 46246

29d. Date signed (Month, Day, Year)

August, 11 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ashraf M. Meelu MD 10 St. Patrick Drive, Suite 105, Waldorf, Maryland 20603

31. Date filed (Month, Day, Year)

AUG 13 1999

32. Registrar's Signature

Signature: [Signature]

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Theodore Milton Kay, Jr.
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Commission of the International
Conference of the American States
Washington, D.C.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26709

| | | | | | | | | |
|--|--|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Althea Catherine Lashbaugh | | | | 2. Date of Death Month Day Year AUGUST 6, 1999 | | 3. Time of Death 9:40 am | |
| | 4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital | | | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany | |
| Funeral Director | 5. Social Security Number 216-09-8507 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 95 Yrs. | | 8. Date of Birth (Month, Day, Year) March 6, 1904 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) Maryland | | 10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10a. State Md | | 10b. County Allegany | | 10c. City, Town or Location Barton | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 18725 Temperance Row | | | | 10f. Zip Code 21521 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Home | | |
| 17. Father's Name (First, Middle, Last) John Robertson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Helena Lyons | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Judy Donaldson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46 Douglas Avenue, Lonaconing, MD 21539 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Laurel Hill Cemetery | | Date 8/8/99 | | 20c. Location - City or Town, State Moscow Mills, MD | | |
| 21. Signature of Funeral Service Licensee 7 Wayne Bul | | | | 22. Name and Address of Facility Boal Funeral Home 111 Church St. Westernport, MD 21562 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Due to (or as a consequence of): b. Severe Aortic Stenosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Conductive Heart Failure, Pneumonia Hypertension, Atherosclerotic Coronary artery disease. | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Thomas J. Devlin | | | | 29c. License number D21488 | | 29d. Date signed (Month, Day, Year) AUGUST 6, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas J. Devlin MD, 20 Douglas Ave, Lonaconing, Md 21539 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 10 1999 | | 32. Registrar's Signature Benjamin B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 26710**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) JAMES RICHARD MYERS, SR. | | | | 2. Date of Death Month August Day 05 Year 1999 | | 3. Time of Death 10 AM | |
| 4a. Facility Name (If not institution, give street and number) Carroll County General Hospital | | | | 4b. City, Town, or Location of Death Westminster | | 4c. County of Death Carroll | |
| 5. Social Security Number 213-38-8483 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F XX | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan 22, 1914 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |

Funeral
Director

| | | | | | | | |
|-------------------------------|--|-------------------------------|--|---|--|--|--|
| 10a. State Maryland | | 10b. County Carroll | | 10c. City, Town or Location Westminster | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
|-------------------------------|--|-------------------------------|--|---|--|--|--|

| | | | | | |
|--|--|-------------------------------|--|---|--|
| 10e. Street and Number 101 Willis Street | | 10f. Zip Code 21157 | | 10g. Citizen of What Country? United States | |
|--|--|-------------------------------|--|---|--|

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
|--|--|---|--|--|--|---|--|

| | | | | | |
|---|--|---|--|---|--|
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dentist | | 16b. Kind of Business/Industry Healthcare | |
|---|--|---|--|---|--|

| | | | |
|---|--|---|--|
| 17. Father's Name (First, Middle, Last) John Edgar Myers, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Abigail Nourse | |
|---|--|---|--|

| | | | |
|--|--|--|--|
| 19a. Informant's Name/Relationship (Type, Print) Dorothy R. Myers/wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Willis Street, Westminster, MD 21157 | |
|--|--|--|--|

| | | | | | |
|---|--|---|--|---|--|
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Westminster Cemetery | | 20c. Location - City or Town, State Westminster, MD | |
|---|--|---|--|---|--|

| | | | |
|---|--|--|--|
| 21. Signature of Funeral Service Licensee Robert A. Myers | | 22. Name and Address of Facility Myers Funeral Home 91 Willis Street Westminster, MD 21157 | |
|---|--|--|--|

| | | | |
|--|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dementia Due to (or as a consequence of): | | Approximate Interval Between Onset and Death Days | |
|--|--|---|--|

| | | | |
|---|--|---|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bowel Obstruction Dementia | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |

| | | | | | | | |
|---|--|---|--|---------------------------------|--|---|--|
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |

| | | | | | | | |
|---|--|--------------------------------------|--|--|--|--|--|
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29c. License number 140525 | | | | | |
|---|--|--------------------------------------|--|--|--|--|--|

| | | | |
|---|--|---|--|
| 29b. Signature and title of certifier Dr. [Signature] | | 29d. Date signed (Month, Day, Year) August 05, 1999 | |
|---|--|---|--|

| | | | |
|--|--|--|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rudolf Litany, M.D. | | Carroll County General Hospital 200 Memorial Ave. Westminster, MD | |
|--|--|--|--|

| | | | |
|---|--|---|--|
| 31. Date filed (Month, Day, Year) AUG 10 1999 | | 32. Registrar's Signature B. Sparks | |
|---|--|---|--|

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

James R. Myers Sr.
Baltimore, Maryland 21215-0020
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26712

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Agnes Clarissa Miller

2. Date of Death

AUGUST

7

1999

3. Time of Death

19:00

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral
Director

5. Social Security Number

232-54-2535

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sep 7, 1912

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

627 Elm Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

nfn

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Shepherd

19a. Informant's Name/Relationship (Type, Print)

Vernon R. Miller

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

627 Elm Street; Cumberland MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Sunset Memorial Park

Date

8/10/

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home P.A.
Cumberland, Maryland 2150223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CEREBRAL HEMORRHAGE

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 weeks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. Gupta

29c. License number

D33280

29d. Date signed (Month, Day, Year)

AUGUST 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUNIL K. GUPTA, MD 625 KENT AVENUE, SUITE 101, CUMBERLAND, MD

21502

31. Date filed (Month, Day, Year)

AUG 11 1999

32. Registrar's Signature

S. Gupta

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AGNES MILLER 232542535

Division of Vital Records, P.O. Box 68760,

Certificate of Death

Reg. No.

99 26713

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred S. McMillan

2. Date of Death

Aug 8, 1999

3. Time of Death

08:05pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Cumberland Nursing Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

217-10-6796

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar 29, 1910

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

717 Montgomery Avenue

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Bead Room

16b. Kind of Business/Industry

Tire Company

17. Father's Name (First, Middle, Last)

William W. Sterner

18. Mother's Name (First, Middle, Maiden Surname)

Edith Meyers

19a. Informant's Name/Relationship (Type, Print)

Eleanor Proudfoot
sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

406 Warwick Avenue; Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hillcrest Memorial Par8/11/ Cumberland, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Family

Scarpelli Funeral Home P.A.
Cumberland, Maryland 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a.

Renal failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 weeks

b.

Dehydration

Due to (or as a consequence of):

2 weeks

c.

Parkinson's Disease

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical
examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury
(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Pete Schur

29c. License number

D04981

29d. Date signed (Month, Day, Year)

August 9, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. H. ALMO 302 SCHREY ST Cumberland, Md.

31. Date filed (Month, Day, Year)

AUG 11 1999

32. Registrar's Signature

B. Spence

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
important: If item 27 is marked other than "natural" or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended #20c, Inds,
8/11/99, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 26714**
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOSEPH EUGENE MEADOWS | | | | 2. Date of Death Month Day Year August 8, 1999 | | 3. Time of Death 1515 | |
| | 4a. Facility Name (If not Institution, give street and number) SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death CUMBERLAND | | 4c. County of Death ALLEGANY | |
| Funeral Director | 5. Social Security Number 223-46-0216 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) JUNE 10, 1937 | |
| | 9. Birthplace (State or Foreign Country) VIRGINIA | | 10a. State WV | | 10b. County MINERAL | | 10c. City, Town or Location FORT ASHBY | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number ROUTE 28 | | 10f. Zip Code 26719 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: '58-'61 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINIST | | 16b. Kind of Business/Industry CELANESE CORP. | | | | |
| 17. Father's Name (First, Middle, Last) JOSEPH S. MEADOWS | | | | 18. Mother's Name (First, Middle, Maiden Surname) ROSA L. SEAY | | | | |
| 19a. Informant's Name/Relationship (Type, Print) BETTY LOU MEADOWS / WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 215 - FORT ASHBY, WV 26719 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) FORT ASHBY CEMETERY | | Date 8/11/99 | | 20c. Location - City or Town, State FORT ASHBY, CUMBERLAND, MD | | |
| 21. Signature of Funeral Service Licensee <i>Wendell R. Upchurch</i> | | | | 22. Name and Address of Facility UPCHURCH FUNERAL HOME, INC. P.O. BOX 1260 - FORT ASHBY, WV 26719 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Bronchogenic Carcinoma</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death 2 yrs | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Pulmonary Disease</i> | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Wayne C. Spisak</i> | | 29c. License number D11443 | | 29d. Date signed (Month, Day, Year) August 10, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne C. Spisak, MD - 912 Sector Dr, Cumberland, MD 21502 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | 32. Registrar's Signature <i>Wayne C. Spisak</i> | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26715

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER WILLIAM MILLER

2. Date of Death

Month
August

Day

c9

Year

1999

3. Time of Death

9:25 PM

4a. Facility Name (If not Institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

170-12-6412

6. Sex

1 ☐ M 2 ☐ F
XX

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
OCT 1 1911

9. Birthplace (State or Foreign Country)

PENNA

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

HARFORD

10c. City, Town or Location

JOPPA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1009 PHILADELPHIA RD

10f. Zip Code

21085

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

MECHANIC

16b. Kind of Business/Industry

AEROSPACE

17. Father's Name (First, Middle, Last)

RICHARD MILLER

18. Mother's Name (First, Middle, Maiden Summa)

MALINDA MILLER

19e. Informant's Name/Relationship (Type, Print)

VICTOR MILLER/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17 REDFIELD CT, BALTIMORE, MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

UNION CEMETERY

Date

8-14-99

20c. Location - City or Town, State

CENTERVILLE, PENNA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DALLA VALLE FUNERAL SVC INC, PO BOX 179
EVERETT PA, 1553723e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Hemorrhagic shock

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 hrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Myocardial infarction

Due to (or as a consequence of):

3 weeks

c. Cardiomyopathy

Due to (or as a consequence of):

4 weeks

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prerenal azotemia

Congestive Heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

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28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Harrison Johnson MD

29c. License number

AT 2438946

29d. Date signed (Month, Day, Year)

August 09, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Harrison Johnson MD, Union Memorial Hospital

31. Date filed (Month, Day, Year)

AUG 13 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 23e show
any injury or other traumatic event, the Medical Examiner must be notified at
605-858-6000.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26716
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---------------------------------------|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Genevieve Mae Magruder | | | | 2. Date of Death Month Aug Day 11 Year 1999 | | 3. Time of Death 06:05am | |
| | 4a. Facility Name (If not institution, give street and number) Cumberland Nursing Home | | | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany | |
| Funeral Director | 5. Social Security Number 214-07-2779 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 89 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth Month Mar Day 17 Year 1910 | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State WV | | 10b. County Mineral | | 10c. City, Town or Location Ridgeley | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 37 Second Avenue | | | | 10f. Zip Code 26753 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | |
| 17. Father's Name (First, Middle, Last) Chester Kifer | | | | 18. Mother's Name (First, Middle, Maiden Surname) Dessie (Kinser) | | | | |
| 19e. Informant's Name/Relationship (Type, Print) Robert H. Magruder husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 Second Avenue; Ridgeley, WV 26753 | | | | |
| 20a. Manner of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Par8/13/ Cumberland, MD | | Date | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee <i>Nicholas J. Scarpelli</i> | | | | 22. Name and Address of Facility Scarpelli Funeral Home P.A. Cumberland, Maryland 21502 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Lung Carcinoma Due to (or as a consequence of): b. Unknown Primary Tumor Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 3 mths |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Accident | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number D33280 | | 29d. Date signed (Month, Day, Year) August 13, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil K. Gupta M.D. 625 Kent Avenue Cumberland MD 21502 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 13 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Yas

State
Registrar

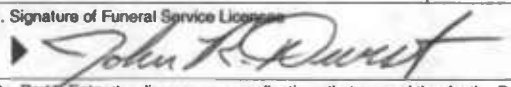
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26717

AMENDS: ITEMS: #23 PART I, 27 PER MEO G775 9-9-99 WR. **Certificate of Death**

Reg. No.

| | | | | | | | | |
|--|--|---|----------------------------|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Gary J. Minnick | | | | 2. Date of Death Month: August Day: 09 Year: 1999 | | 3. Time of Death 11:03 AM. | |
| | 4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital | | | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany | |
| Funeral Director | 5. Social Security Number 213-06-2503 | | 6. Sex 10 M 20 F | 7. Age (In yrs. last birthday) 30 | If Under 1 Year Months: Days: | If Under 24 Hrs. Hours: Min. | 8. Date of Birth (Month, Day, Year) 04-Apr-69 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Allegany | | 10c. City, Town or Location Frostburg | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 11609 Dobbin Drive, N.W. | | | | 10f. Zip Code 21532- | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (14 or 5+): 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) heavy equipment operator | | 16b. Kind of Business/Industry coal mining | | |
| 17. Father's Name (First, Middle, Last) Robert Minnick | | | | 18. Mother's Name (First, Middle, Maiden Surname) Isabel Caton | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert Minnick Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11519 Dobbin Drive, N.W. Frostburg Maryland 21532 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Finzel Cemetery | | 20c. Location - City or Town, State 13-Aug-99 Finzel, Maryland | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARRHYTHMIA ASSOCIATED WITH MYOCARDIAL FIBROSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) August 10, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 16 1999 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26718

| | | | | | | | | | | |
|---|---|--|---|-------------------------------|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JEAN ELOISE MONROW | | | | 2. Date of Death Month Day Year AUGUST 5, 1999 | | | | 3. Time of Death 3:40 PM | |
| | 4a. Facility Name (If not institution, give street and number) GARRETT COUNTY MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death OAKLAND | | | | 4c. County of Death GARRETT | |
| Funeral Director | 5. Social Security Number 179-14-5923 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) OCT 31, 1922 | | 9. Birthplace (State or Foreign Country) PA | |
| | Usual Residence of Decedent | | | | 10a. State MD | | 10b. County GARRETT | | 10c. City, Town or Location OAKLAND | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number 706 E. ALDER STREET | | 10f. Zip Code 21550 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | | 16b. Kind of Business/Industry OWN HOME | | | | |
| | 17. Father's Name (First, Middle, Last) RAY H. KEIM | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARY ARMTRIESTER | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) NANCY ZIEGLER - DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 366 ST. PETER'S, PA 19470-0366 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) OMEGA CREMATORY | | 20c. Location - City or Town, State 8/6/99 MORGANTOWN, WV | | | | | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility P.O. BOX 243 DURST FUNERAL HOME OAKLAND, MD 21550 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 1 day | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dementia | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | | | | | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D25759 | | | | | | |
| 29d. Date signed (Month, Day, Year) August 5, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter K. Naumann, M.D., PO Box 247, Accident MD 21520 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG - 9 1999 | | 32. Registrar's Signature | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

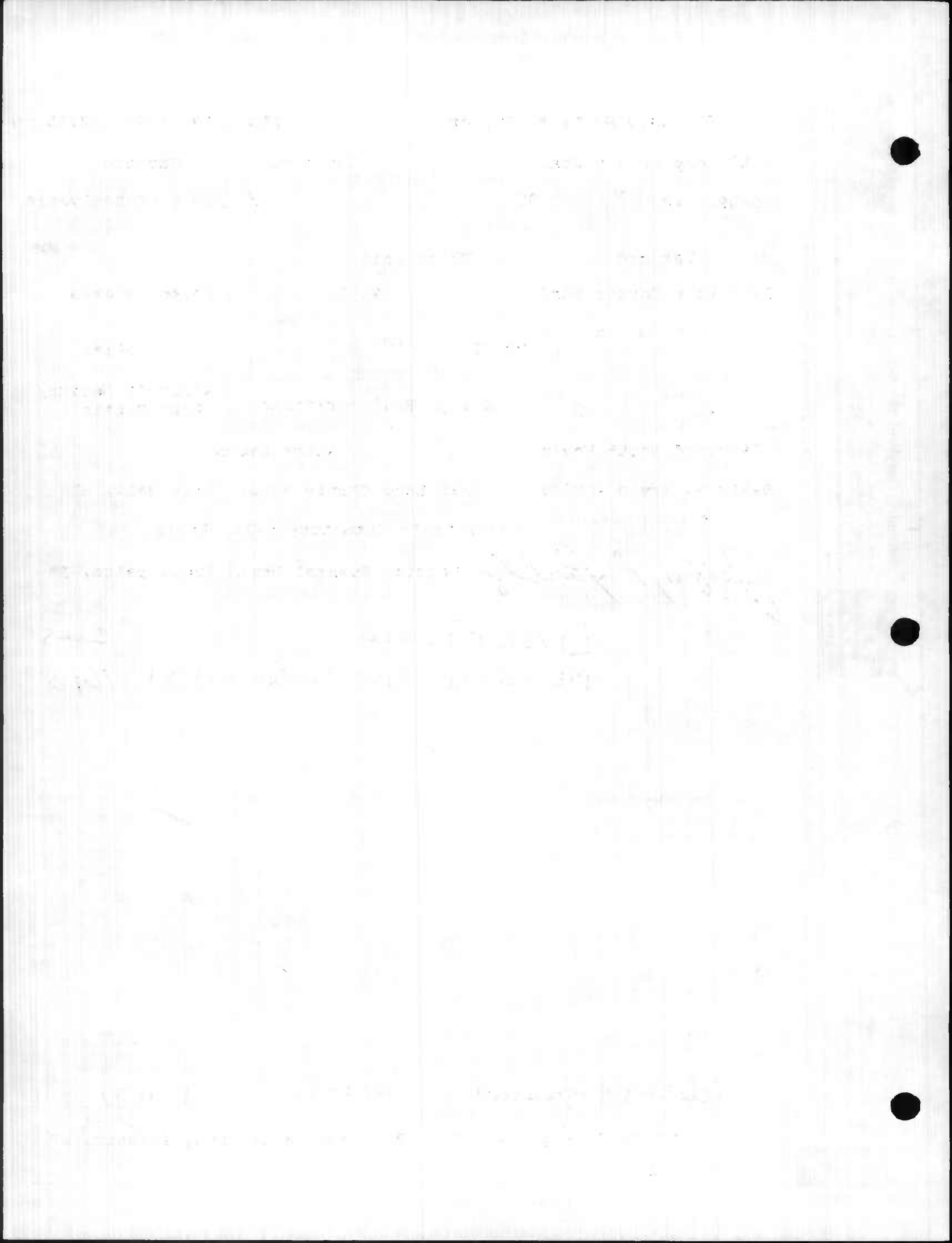
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26719

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|--|---|--------------------------------|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) KIRKWOOD SCOTT NEVIN, Jr. | | | | 2. Date of Death Month Day Year AUG 10 1999 | | 3. Time of Death 12:35 pm | |
| | 4a. Facility Name (If not institution, give street and number) 5230 Long Corner Road | | | | 4b. City, Town, or Location of Death White Hall | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 210-09-2148 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 80 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 11/11/1918 | 9. Birthplace (State or Foreign Country) Pennsylvania |
| | Usual Residence of Decedent | | | | 10a. State MD | | 10b. County Harford | |
| To Be Completed by Funeral Director | 10c. City, Town or Location White Hall | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 5230 Long Corner Road | |
| | 10f. Zip Code 21161 | | | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Design Engineer/Farmer | | 16b. Kind of Business/Industry Aircraft Design/ Beef Cattle | | | |
| | 17. Father's Name (First, Middle, Last) Kirkwood Scott Nevin | | | | 18. Mother's Name (First, Middle, Maiden Surname) Wilma Damon | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Sally W. Nevin - Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5230 Long Corner Road, White Hall, MD | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Evans-Eagle Crematory 8/11 | | 20c. Location - City or Town, State Leola, PA | | 21. Signature of Funeral Service Licensee <i>Jeffrey P. Lovelidge</i> | |
| | 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA | | | | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. LIVER FAILURE | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | |
| | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <i>Walter R. Hepner</i> | | | |
| | 29c. License number D23450 | | | | 29d. Date signed (Month, Day, Year) 8-11-99 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter R. Hepner, M.D., 3346 Paper Mill Road, Phoenix, MD | | | | 31. Date filed (Month, Day, Year) AUG 12 1999 | | | |
| | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 26720**
Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|-------------------------------|---|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Virgie Mae Norman | | | | | 2. Date of Death Month August Day 11 Year 1999 | | | 3. Time of Death | | |
| | 4a. Facility Name (If not institution, give street and number) Dulaney-Towson Health Care Center | | | | | 4b. City, Town, or Location of Death Towson | | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 215-14-8118 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 31, 1917 | | 9. Birthplace (State or Foreign Country) N. Carolina | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Harford | | 10c. City, Town or Location White Hall | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 3139 Dry Branch Rd. | | | | 10f. Zip Code 21161 | | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | | | |
| 17. Father's Name (First, Middle, Last) Tyre Montgomery Atkins | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Jettie (u/k) Abscher | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert D. Norman - Son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3139 Dry Branch Rd., White Hall, MD 21161 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardens | | | Date 8-14-99 | | 20c. Location - City or Town, State Bel Air, Maryland | | | |
| 21. Signature of Funeral Service Licensee <i>Charles A. Emery</i> | | | | | 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | a. Congestive Heart Failure | | | | | | 2 Years | | |
| | | | b. Atrial Fibrillation | | | | | | 1 Year | | |
| | | | c. | | | | | | | | |
| | | | d. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier <i>Dr. [Signature]</i> Attending Physician | | | 29c. License number D53642 | | 29d. Date signed (Month, Day, Year) Aug. 12 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Xiao Ming Zhou 3007 E Northern Park way Baltimore | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1999 | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NORMAN, VIRGIE
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21268-0760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26721

| | | | | | | | | | | | |
|---|---|-------------------------------|---|---|--|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jerusha Mitchell Oliver | | | | | | 2. Date of Death Month Day Year August 10, 1999 | | 3. Time of Death | | |
| | 4a. Facility Name (If not Institution, give street and number) 634 Burkley Avenue | | | | | | 4b. City, Town, or Location of Death Aberdeen | | 4c. County of Death Harford | | |
| Funeral Director | 5. Social Security Number 212-56-3126 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 3, 1908 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Harford | | 10c. City, Town or Location Aberdeen | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number 634 Burkley Avenue | | | | 10f. Zip Code 21001 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry In home | | | | |
| 17. Father's Name (First, Middle, Last) Malcolm Walker Mitchell | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Eva Gertrude Osborn | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Charles M. Oliver (Son) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Patterson Mill Road, Bel Air, MD 21015 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Grove Presbyterian Cemetery | | | Date 8/14/99 | | 20c. Location - City or Town, State Aberdeen, Maryland | | | |
| 21. Signature of Funeral Service Licensee <i>Kenneth B. Gays</i> | | | | | | 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>ACUTE MYOCARDIAL INFARCTION</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. <i>None</i> Due to (or as a consequence of): c. <i>None</i> Due to (or as a consequence of): d. <i>None</i> | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - Dementia - VSA - CAD | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | | 29c. License number 042800 | | 29d. Date signed (Month, Day, Year) 8/11/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. Blondo MD 314 S. Union Ave Ad6, Md 20788 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1999 | | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26722

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|--|---|---|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>MURIEL Percy</i> | | | | 2. Date of Death Month <i>August</i> Day <i>7</i> Year <i>1999</i> | | 3. Time of Death <i>11:30am</i> | | |
| | 4a. Facility Name (If not institution, give street and number) <i>5875 Springmount Court</i> | | | | 4b. City, Town, or Location <i>Eldersburg</i> | | 4c. County of Death <i>Carroll</i> | | |
| Funeral Director | 5. Social Security Number <i>112-09-8362</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>92</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>Mar 20, 1907</i> | | |
| | 9. Birthplace (State or Foreign Country) <i>Pennsylvania</i> | | 10a. State <i>MD</i> | | 10b. County <i>Carroll</i> | | 10c. City, Town or Location <i>Eldersburg</i> | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number <i>5875 Springmount Court</i> | | 10f. Zip Code <i>21784</i> | | 10g. Citizen of What Country? <i>U.S.A.</i> | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | | | |
| 15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>LPN</i> | | 16b. Kind of Business/Industry <i>Health Care</i> | | | | | |
| 17. Father's Name (First, Middle, Last) <i>Alva Davies</i> | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Mazie Schyrock</i> | | 19a. Informant's Name/Relationship (Type, Print) <i>Mrs. Sarah J. Hajduk (DAUGHTER)</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5875 Springmount Ct. Eldersburg, MD 21784</i> | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Carroll Cremation Serv.</i> | | Date <i>8/10/99</i> | | 20c. Location - City or Town, State <i>Hampstead, MD</i> | | | |
| 21. Signature of Funeral Service Licensee <i>Brian L. Haight</i> | | 22. Name and Address of Facility <i>HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400</i> | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Interstitial Lung disease</i> Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>5 years</i> | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>myelodysplastic syndrome</i> | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>MURIEL Percy</i> | | 29c. License number <i>MD 050778</i> | | 29d. Date signed (Month, Day, Year) <i>August 9, 1999</i> | | | |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print) <i>Michelle Rice Cross 211K Patuxent Pkwy Columbia, MD 21046</i> | | 31. Date filed (Month, Day, Year) <i>AUG 11 1999</i> | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26723

| | | | | | | | | | | |
|--|---|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GRANT LEO RUBY SR. | | | | 2. Date of Death Month Day Year August 10 1999 | | | | 3. Time of Death 17:40 PM | |
| | 4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death CUMBERLAND | | | | 4c. County of Death ALLEGANY | |
| Funeral Director | 5. Social Security Number 215-34-4298 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 64 Yrs. | | 8. Date of Birth (Month, Day, Year) FEB 7 1935 | | 9. Birthplace (State or Foreign Country) PA. | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State PA. | | 10b. County BEDFORD | | 10c. City, Town or Location CLEARVILLE | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 2109 FLINTSTONE CREEK ROAD | | | | 10f. Zip Code 15535 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates U.S. ARMY | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) KELLY SPRINGFIELD TIRE CO. TRUCK DRIVER | | | | 16b. Kind of Business/Industry | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) HARRY FRANCIS RUBY | | | | 18. Mother's Name (First, Middle, Maiden Surname) BESSIE HEAVNER | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) HILDA I. RUBY WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2109 FLINTSTONE CREEK ROAD CLEARVILLE PA 15535 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BEANS COVE METHODIST CEMETERY AUG 13 1999 BEANS COVE PA. | | 20c. Location - City or Town, State | | | | | |
| | 21. Signature of Funeral Service Licensee Dale L. Merritt | | | | 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death | |
| | Immediate Cause (Final disease or condition resulting in death) a. NON-SMALL CELL CARCINOMA OF LUNG Due to (or as a consequence of): | | | | | | | | 2/1999 | |
| | Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): | | | | | | | | unknown | |
| | c. Due to (or as a consequence of): d. | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and Title of certifier [Signature] | | | | 29c. License number D23371 | | 29d. Date signed (Month, Day, Year) August 11, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Zaman Johnson Heights Medical Bldg., 625 Kent Avenue, Cumberland, MD 21502 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 12 1999 | | | | 32. Registrar's Signature [Signature] | | | | | |
| | | | | | | | | | | |




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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26724

| | | | | | | | | | | |
|---|--|---|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Joseph Cortez Resh | | | | 2. Date of Death Month Day Year August 4, 1999 | | | | 3. Time of Death 1806 | |
| | 4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital | | | | 4b. City, Town, or Location of Death Cumberland | | | | 4c. County of Death Allegany | |
| Funeral Director | 5. Social Security Number 212-18-1003 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug 23, 1907 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | 10a. State MD | | 10b. County Garrett | | 10c. City, Town or Location Grantsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 15925 Bittering Road | | 10f. Zip Code 21536 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Heavy equipment operator | | | | 16b. Kind of Business/Industry Fire Brick Manufacture | |
| | 17. Father's Name (First, Middle, Last) Simon Resh | | | | 18. Mother's Name (First, Middle, Maiden Surname) Harriet Wiley | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Ruthella J. Resh/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15925 Bittering Rd., Grantsville, MD 21536 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Grantsville Cem. | | Date Aug 8, 1999 | | 20c. Location - City or Town, State Grantsville, MD | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Newman Funeral Homes, P.A., P.O. Box 275 179 Miller St., Grantsville, MD 21536 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>cardiopulm arrest</u> Due to (or as a consequence of): b. <u>CHF</u> Due to (or as a consequence of): c. <u>COPD</u> Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death immediate | | | | | |
| | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Aug - 17 4, 1999 | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 15925 Bittering Road, Grantsville, Maryland | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier  | | | | 29c. License number H0053855 | | |
| | | | | 29d. Date signed (Month, Day, Year) August 5, 1999 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stanky Joseph Matyask, DO Sacred Heart Hospital, 900 Jefferson Drive, Maryland | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG - 6 1999 | | | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26725

| | | | | | | | | | | | | | | |
|---|--|-------------------------------|--|--|---|--|--------------------------------|--|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ARTHUR EUGENE RODEHEAVER | | | | 2. Date of Death Month Day Year AUGUST 6, 1999 | | | | 3. Time of Death 11:36 PM | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 104 OAK DRIVE | | | | 4b. City, Town, or Location of Death GRANTSVILLE | | | | 4c. County of Death GARRETT | | | | | |
| Funeral Director | 5. Social Security Number 213-12-9356 | | 8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday) 77 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) NOV 25, 1921 | | 9. Birthplace (State or Foreign Country) MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County GARRETT | | 10c. City, Town or Location GRANTSVILLE | | | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number 104 OAK DRIVE | | | | 10f. Zip Code 21536 | | | | 10g. Citizen of What Country? USA | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR | | | | 16b. Kind of Business/Industry US GOVERNMENT | | | | | | |
| 17. Father's Name (First, Middle, Last) JOSHUA A. RODEHEAVER | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) EMILY MARGARET MOON | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MARIAN K. RODEHEAVER - WIFE | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 OAK DRIVE GRANTSVILLE, MD 21536 | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) PLEASANT VALLEY CEMETERY | | | | Date 8/8/99 | | 20c. Location - City or Town, State OAKLAND, MARYLAND | | | | |
| 21. Signature of Funeral Service Licensee  MO0167 | | | | 22. Name and Address of Facility P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550 | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | | | Approximate Interval Between Onset and Death 1 YEAR | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | | 29c. License number D26568 | | 29d. Date signed (Month, Day, Year) AUGUST 7, 1999 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROGER A. LEWIS, M.D. 510 W. STATE STREET TERRA ALTA, WV 26764 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG - 9 1999 | | | | 32. Registrar's Signature  | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used.

3. The third part is a discussion of the results obtained.

4. The fourth part is a conclusion and summary of the work.

5. The fifth part is a list of references.

6. The sixth part is a list of figures.

7. The seventh part is a list of tables.

8. The eighth part is a list of appendices.

9. The ninth part is a list of footnotes.

10. The tenth part is a list of symbols.

11. The eleventh part is a list of abbreviations.

12. The twelfth part is a list of acronyms.

13. The thirteenth part is a list of definitions.

14. The fourteenth part is a list of terms.

15. The fifteenth part is a list of phrases.

16. The sixteenth part is a list of sentences.

17. The seventeenth part is a list of paragraphs.

18. The eighteenth part is a list of sections.

19. The nineteenth part is a list of chapters.

20. The twentieth part is a list of volumes.

21. The twenty-first part is a list of issues.

22. The twenty-second part is a list of parts.

23. The twenty-third part is a list of pages.

24. The twenty-fourth part is a list of lines.

25. The twenty-fifth part is a list of words.

26. The twenty-sixth part is a list of letters.

27. The twenty-seventh part is a list of numbers.

28. The twenty-eighth part is a list of symbols.

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26726

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CATHERINE ANN ROLAND | | | | 2. Date of Death Month Day Year August 11 1999 | | 3. Time of Death 8:30 PM | |
| | 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Center | | | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 215-54-7269 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 49 Yrs. | | 8. Date of Birth (Month, Day, Year) June 5, 1950 | |
| | 9. Birthplace (State or Foreign Country) Washington, DC | | 10a. State Maryland | | 10b. County Charles | | 10c. City, Town or Location Waldorf | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 11626 Kipling Drive | | 10f. Zip Code 20601 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business Owner | | 16b. Kind of Business/Industry Retail Carpet Sales | | | |
| | 17. Father's Name (First, Middle, Last) Lewis M. Jones | | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen May Lynch | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Robert R. Roland/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11626 Kipling Drive, Waldorf, Maryland 20601 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Grove Cemetery | | 20c. Location - City or Town, State LaPlata, Maryland | | 20d. Date 8-14-1999 | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee JOHN P. KNISLEY M01164 | | | | 22. Name and Address of Facility The Hunt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland 20604 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Urinary tract infection Due to (or as a consequence of): c. Ureteral obstruction Due to (or as a consequence of): d. Colon cancer | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Frank R. Dumais, MD | | 29c. License number D 53813 | |
| | 29d. Date signed (Month, Day, Year) 8/12/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Dumais M.D. 7503 Burrhead Rd Clinton, MD 20735 | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 13 1999 | | | | 32. Registrar's Signature B. Sparks | | | |

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State of Maryland / Department of Health and Mental Hygiene 99 26727

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John William Shores | | | | 2. Date of Death Month Day Year August 11 1999 | | 3. Time of Death 8:15 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) 714 Beards Hill Road | | | | 4b. City, Town, or Location of Death Aberdeen | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 217-12-0901 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | | 8. Date of Birth (Month, Day, Year) Mar. 3, 1925 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Harford | | 10c. City, Town or Location Aberdeen | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 714 Beards Hill Road | | 10f. Zip Code 21001 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver/Route salesman | | 16b. Kind of Business/Industry Diary | | | | |
| 17. Father's Name (First, Middle, Last) William B. Shores | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ella Riley | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Margaret K. Shores (Spouse) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 714 Beards Hill Road, Aberdeen, Maryland 21001 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baker Cemetery | | Date 8/13/99 | | 20c. Location - City or Town, State Aberdeen, Maryland | | |
| 21. Signature of Funeral Service Licensee Kenneth B. Cargo | | | | 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic pancreatic carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 2 mo. | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Charles Eck | | 29c. License number D31712 | | 29d. Date signed (Month, Day, Year) 8/12/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES ECK JR 219 W. BELAIR AVE. ABERDEEN, MD 21001 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1999 | | 32. Registrar's Signature James B. Smith | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Certificate of Death

Reg. No.

99 26728

| | | | | | |
|---|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Grace M. Snider | | 2. Date of Death Month Aug , Day 7 , Year 1999 | | 3. Time of Death 12:10am |
| | 4a. Facility Name (If not institution, give street and number) Cumberland Nursing Center | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany |
| Funeral Director | 5. Social Security Number 141-32-3260 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | 8. Date of Birth Month Jul , Day 29 , Year 1912 | 9. Birthplace (State or Foreign Country) NJ |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State NJ | 10b. County Essex | 10c. City, Town or Location Cedar Grove | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 102 Brunswick Road | | 10f. Zip Code 07009 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | |
| | 17. Father's Name (First, Middle, Last) George McLaughlin | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret (Carroll) | | |
| | 19a. Informant's Name/Relationship (Type, Print) George Snider | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Brunswick Road; Cedar Grove, NJ 07009 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peters Cemetery | | 20c. Location - City or Town, State 8/10/ New Brunswick, NJ |
| | 21. Signature of Funeral Service Licensee <i>Nicholas J. Scarpelli</i> | | 22. Name and Address of Facility Scarpelli Funeral Home P.A. Cumberland, Maryland 21502 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) Renal failure | | Due to (or as a consequence of): Dehydration | | Approximate Interval Between Onset and Death 2 weeks |
| | Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Due to (or as a consequence of): Organic Brain Syndrome | | 2 weeks |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Organic Brain Syndrome | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>Peter J. Celmer</i> | | 29c. License number DO 4981 | | 29d. Date signed (Month, Day, Year) August 7, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. HALMOS 302 SCHLEY ST. CUMBERLAND. Md. | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 11 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26729

| | | | | | | | | | | | | |
|--|--|---|---|--------------------------|--|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Philomena Virginia Small | | | | 2. Date of Death Month Day Year August 10, 1999 | | | | 3. Time of Death 20:55 | | | |
| | 4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death CUMBERLAND | | | | 4c. County of Death ALLEGANY | | | |
| Funeral Director | 5. Social Security Number 214-34-2004 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) 2-12-1912 | | 9. Birthplace (State or Foreign Country) USA | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Allegany | | 10c. City, Town or Location Westernport | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number 407 Maryland Avenue | | | | 10f. Zip Code 21562 | | 10g. Citizen of What Country? USA | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 3 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse | | | | 16b. Kind of Business/Industry Pulp & Paper Mill | | | | | |
| | 17. Father's Name (First, Middle, Last) William F. Burns | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth C. Studd | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) James T. Small, Jr. -Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 2224 Waukesha, WI 53187 | | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory | | Date 8-11-99 | | 20c. Location - City or Town, State Cumb. MD 21502 | | | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Fredlock Funeral Home P.O. Box 4, Piedmont, WV | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death 4 days | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | | | 29c. License number D35481 | | 29d. Date signed (Month, Day, Year) August 11th, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Sagin, M.D., Memorial Hospital Suite 400 Cumberland MD 21502 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 13 1999 | | 32. Registrar's Signature | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26730

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LORETTA M. TIMBROOK

2. Date of Death

Month Day Year

AUGUST

7

1999

3. Time of Death

10:00PM

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

234-44-6938

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
March 7, 1930

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

WV

10b. County

Mineral

10c. City, Town or Location

Keyser

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Rt. 1, Box 161-F

10f. Zip Code

26726

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Victor C. Decker

18. Mother's Name (First, Middle, Maiden Summa)

Ruby M. Anderson

19a. Informant's Name/Relationship (Type, Print)

Vicki R. Klavuhn/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 2, Box 219 Ridgeley, WV 26753

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Biser Cemetery

Data

Aug. 10

1999

20c. Location - City or Town, State

Keyser, WV

21. Signature of Funeral Service Licensee

Brenda L. Smith

22. Name and Address of Facility

Smith Funeral Home

85 S. Main Street Keyser, WV 26726

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Mycobacterium avium-intracellulare pneumonia infection

Approximate Interval Between Onset and Death

5 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wayne C. Spiegler

29c. License number

D11443

29d. Date signed (Month, Day, Year)

AUGUST 9 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wayne C. Spiegler, M.D. 912 Seton Drive Cumberland MD 21502

31. Date filed (Month, Day, Year)

AUG 12 1999

32. Registrar's Signature

B. Spiegler

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at 300-666.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

ms

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26732

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--------------------------------------|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) NATALIE ROBISON TODD | | | | 2. Date of Death Month Day Year August 11 1999 | | 3. Time of Death 0800 | |
| 4a. Facility Name (If not institution, give street and number) Chesapeake Woods Center | | | | 4b. City, Town, or Location of Death Cambridge | | 4c. County of Death Dorchester | |
| 5. Social Security Number 214-07-7359 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 | 8. Date of Birth (Month, Day, Year) July 10 1912 | 9. Birthplace (State or Foreign Country) Pennsylvania | | |
| Usual Residence of Decedent | | | | | | | |
| 10e. State MD | | 10b. County Dorchester | | 10c. City, Town or Location Cambridge | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 525 Glenburn Ave. | | | | 10f. Zip Code 21613 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) receptionist | | 16b. Kind of Business/Industry medical | |
| 17. Father's Name (First, Middle, Last) Roy ROBISON | | | | 18. Mother's Name (First, Middle, Maiden Surname) Hazel Gerlach | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ms. Mary Ann Todd-daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13641 Ambassador Drive, Germantown, MD 20874 | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory | | Date 8-14-99 | | 20c. Location - City or Town, State Salisbury, Maryland | |
| 21. Signature of Funeral Service Licensee Kenneth R. Thomas Jr. | | | | 22. Name and Address of Facility Thomas Funeral Home, PA 700 Locust St. Cambridge MD 21613 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral myelopathy | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier Michael Falkner | | | | 29c. License number D26388 | | 29d. Date signed (Month, Day, Year) Aug 11, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Michael Falkner MD 302 Collins Harlock MD 21643 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1999 | | 32. Registrar's Signature B. Sparks | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permits. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMEND ITEMS: #5, 18 PER MEO G775

9-28-99 WR 99 26733

TAYLOR, JOHN

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner
Funeral Director

| | | | | | |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) JOHN ALEXANDER TAYLOR | | 2. Date of Death Month Day Year AUGUST 14 1999 | | 3. Time of Death 8:20 A.M. | |
| 4a. Facility Name (If not institution, give street and number) BERLIN NURSING HOME | | 4b. City, Town, or Location of Death BERLIN | | 4c. County of Death WORCESTER | |
| 5. Social Security Number 143-10-3717 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | |
| 8. Date of Birth (Month, Day, Year) JUNE 26, 1913 | | 9. Birthplace (State or Foreign Country) Lachienne, CANADA | | | |
| 10a. State DELAWARE | | 10b. County SUSSEX | | 10c. City, Town or Location LEWES | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1140 SAVANNAH ROAD | | 10f. Zip Code 19958 | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER | | 16b. Kind of Business/Industry HIGHWAY DEPARTMENT | | 17. Father's Name (First, Middle, Last) JOHN TAYLOR | |
| 18. Mother's Name (First, Middle, Maiden Surname) JANE CAMPBELL McCULL MUNGALL | | 19a. Informant's Name/Relationship (Type, Print) PATRICIA ANN STEINBRICK | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 423 PROVIDENCE PIKE, PUTNAM, CT 06260 | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) EASTERN SHORE CREMATORIUM | | 20c. Location - City or Town, State LEWES, DELAWARE | |
| 21. Signature of Funeral Service Licensee MOO866 | | 22. Name and Address of Facility PARSELL FUNERAL HOMES & CREMATORIUM 1449 KINGS HIGHWAY, LEWES, DE 19958 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. HYPERTENSION Due to (or as a consequence of): c. Due to (or as a consequence of): d. | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier EDWIN CASTANEDA M.D. | | 29c. License number 046257 | |
| 29d. Date signed (Month, Day, Year) 8/14/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9714 Heartaway Drive, Berlin, MD 21811 | | 31. Date filed (Month, Day, Year) AUG 25 1999 | |
| 32. Registrar's Signature B. Sparks | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 15, per F.D.
8/10/99, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26734

| | | | | | | | | | | |
|--|---|-------------------------------|--|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LAWRENCE WILKES WEBSTER | | | | | | 2. Date of Death Month Day Year AUGUST 9, 1999 | | 3. Time of Death 6:10AM | |
| | 4a. Facility Name (If not institution, give street and number) 62 B SOUTH COLONIAL AVENUE | | | | | | 4b. City, Town, or Location of Death WESTMINSTER | | 4c. County of Death CARROLL | |
| Funeral Director | 5. Social Security Number 579-40-9379 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) AUG. 8, 1931 | | 9. Birthplace (State or Foreign Country) PA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County CARROLL | | 10c. City, Town or Location WESTMINSTER | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 62 B SOUTH COLONIAL AVENUE | | | | 10f. Zip Code 21157 | | 10g. Citizen of What Country? UNITED STATES | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-53 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 16 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHIEF MEDICAL TECH. | | | 16b. Kind of Business/Industry HEALTH CARE | | | |
| 17. Father's Name (First, Middle, Last) LAWRENCE WEBSTER | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) DOROTHY CARTWRIGHT | | | | |
| 19a. Informant's Name/Relationship (Type, Print) M. LYNN EARP/DAUGHTER | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 BOXWOOD AVE. WESTMINSTER, MD 21157 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CARROLL CREMATORY | | | 20c. Date 8/13/99 | | 20d. Location - City or Town, State HAMPSTEAD, MD | | |
| 21. Signature of Funeral Service Licensee  | | | | | | 22. Name and Address of Facility 91 WILLIS STREET MYERS FUNERAL HOME WESTMINSTER, MD 21157 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. GLIOBLASTOMA BRAIN Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier  | | | 29c. License number D26385 | | 29d. Date signed (Month, Day, Year) 8-10-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Norman Galbreath; 218 Washington Heights Rd. Westminster, MD 21157 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 10 1999 | | | 32. Registrar's Signature  | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at 2025.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26735

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|-------------------------------------|---|--|--|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Homer B. Warehime | | | | 2. Date of Death Month Day Year Aug. 10 1999 | | | | 3. Time of Death 1:55 am | |
| | 4a. Facility Name (If not institution, give street and number) 38 West George Street | | | | 4b. City, Town, or Location of Death Westminster | | | | 4c. County of Death Carroll | |
| Funeral Director | 5. Social Security Number 219-14-8645 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) Apr 10 1928 | | 9. Birthplace (State or Foreign Country) PA | |
| | Usual Residence of Decedent | | | | 10e. State MD | | 10b. County Carroll | | 10c. City, Town or Location Westminster | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number 38 West George Street | | | | 10f. Zip Code 21157 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sign Manufacturer | | | | 16b. Kind of Business/Industry 3 M | | | | 17. Father's Name (First, Middle, Last) Norman Warehime | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Bertha Brown | | | | 19a. Informant's Name/Relationship (Type, Print) James P. Warehime/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) POB 2210 Westminster, MD 21157 | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadow Branch Cem | | | | 20c. Location - City or Town, State 8/12/99 Westminster, MD | |
| | 21. Signature of Funeral Service Licensee John K. [Signature] | | | | 22. Name and Address of Facility Pritts Funeral Home & Chapel 412 Washington Rd. Westminster, MD 21157 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) pancreatic cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last hypertension | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury M | | | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| State Registrar | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier John A. Steers - physician | | | | 29c. License number #D44614 | |
| | 29d. Date signed (Month, Day, Year) 8/11/99 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John A. Steers, M.D. 295 Stoner Ave Westminster MD 21157 | | | | 31. Date filed (Month, Day, Year) AUG 11 1999 | |
| | 32. Registrar's Signature [Signature] | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

[The page contains extremely faint, illegible text, likely bleed-through from the reverse side. The text appears to be organized into several paragraphs and possibly includes some headings or section numbers.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26736

| | | | | | | | | | | |
|---|--|---|---------------------------------|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Keith Ray Wheeler | | | | 2. Date of Death Month Day Year Aug 5, 1999 | | | | 3. Time of Death 0050 | |
| | 4a. Facility Name (If not institution, give street and number) Garrett Co. Memorial Hospital | | | | 4b. City, Town, or Location of Death Oakland | | | | 4c. County of Death Garrett | |
| Funeral Director | 5. Social Security Number 176 12 6167 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb 2 1921 | | 9. Birthplace (State or Foreign Country) Pa. | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Md | | 10b. County Garrett | | 10c. City, Town or Location Kitzmiller, Md | | | | 10d. Inside City Limits 1 Yes 2 No | | |
| 10e. Street and Number 100 Vindex Rd | | | | 10f. Zip Code 21538 | | | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Patapsco & Backriver R.R. Railroad | | | | 16b. Kind of Business/Industry | | |
| 17. Father's Name (First, Middle, Last) Raymond Wheeler | | | | 18. Mother's Name (First, Middle, Maiden Surname) Edna Mayhorn | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Betty Wheeler | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Vindex Rd. Kitzmiller, Md 21538 | | | | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory | | Date Aug 6 99 | | 20c. Location - City or Town, State Cumberland Md | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility David A. Burdock FH 710 Church St. Kitzmiller, Md 21538 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | a. acute myocardial infarction Due to (or as a consequence of): b. atherosclerotic heart disease Due to (or as a consequence of): c. diabetes mellitus Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death immediate years years | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | |
| | | | | | | 24e. Was an autopsy performed? 1 Yes 2 No | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Piece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29e. Certifier (Check only one) 1 Medical Examiner | | 29f. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D15333 | | 29d. Date signed (Month, Day, Year) 8/5/99 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Thomas G. Johnson, M.D. 311 N. Fourth Street Oakland, MD 21550 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG - 6 1999 | | 32. Registrar's Signature | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26737

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marvin Paul Warnick

2. Date of Death

Month
August

Day

3

Year

1999

3. Time of Death

1:50 AM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

220-16-5834

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 14, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Laytonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4911 Sundown Road

10f. Zip Code

20882

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Revenue Officer

16b. Kind of Business/Industry

Internal Revenue Serv.

17. Father's Name (First, Middle, Last)

William Clay Warnick

18. Mother's Name (First, Middle, Maiden Summa)

Julia Ellen Lee

19a. Informant's Name/Relationship (Type, Print)

Freda W. Warnick/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4911 Sundown Rd., Laytonsville, MD 20882

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Bittinger Cemetery, Aug. 6, 1999

Date

20c. Location - City or Town, State

Bittinger, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Newman Funeral Homes, P.A.

179 Miller St., PO Box 275, Grantsville, MD 21536

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Carcinoma Colon Obstructing

Approximate Interval Between Onset and Death

7 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

14545

29d. Date signed (Month, Day, Year)

8/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL D. SULKIN MD 9715 Medical Center Dr Rockville MD

31. Date filed (Month, Day, Year)

AUG - 6 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1865. The letter is signed by Abraham Lincoln and is addressed to the Senate and House of Representatives. The letter is a copy of the original, which is now in the possession of the Library of Congress.

2. The second part of the document is a letter from the President of the United States to the Congress, dated January 1, 1865. The letter is signed by Abraham Lincoln and is addressed to the Senate and House of Representatives. The letter is a copy of the original, which is now in the possession of the Library of Congress.

3. The third part of the document is a letter from the President of the United States to the Congress, dated January 1, 1865. The letter is signed by Abraham Lincoln and is addressed to the Senate and House of Representatives. The letter is a copy of the original, which is now in the possession of the Library of Congress.

4. The fourth part of the document is a letter from the President of the United States to the Congress, dated January 1, 1865. The letter is signed by Abraham Lincoln and is addressed to the Senate and House of Representatives. The letter is a copy of the original, which is now in the possession of the Library of Congress.

5. The fifth part of the document is a letter from the President of the United States to the Congress, dated January 1, 1865. The letter is signed by Abraham Lincoln and is addressed to the Senate and House of Representatives. The letter is a copy of the original, which is now in the possession of the Library of Congress.

6. The sixth part of the document is a letter from the President of the United States to the Congress, dated January 1, 1865. The letter is signed by Abraham Lincoln and is addressed to the Senate and House of Representatives. The letter is a copy of the original, which is now in the possession of the Library of Congress.

7. The seventh part of the document is a letter from the President of the United States to the Congress, dated January 1, 1865. The letter is signed by Abraham Lincoln and is addressed to the Senate and House of Representatives. The letter is a copy of the original, which is now in the possession of the Library of Congress.

8. The eighth part of the document is a letter from the President of the United States to the Congress, dated January 1, 1865. The letter is signed by Abraham Lincoln and is addressed to the Senate and House of Representatives. The letter is a copy of the original, which is now in the possession of the Library of Congress.

9. The ninth part of the document is a letter from the President of the United States to the Congress, dated January 1, 1865. The letter is signed by Abraham Lincoln and is addressed to the Senate and House of Representatives. The letter is a copy of the original, which is now in the possession of the Library of Congress.

10. The tenth part of the document is a letter from the President of the United States to the Congress, dated January 1, 1865. The letter is signed by Abraham Lincoln and is addressed to the Senate and House of Representatives. The letter is a copy of the original, which is now in the possession of the Library of Congress.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26738

| | | | | | | | | | | | |
|--|--|------------------------|---|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EDWARD GILBERT WETZEL, JR. | | | | 2. Date of Death Month Day Year AUGUST 5, 1999 | | | | 3. Time of Death 11:39 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number) GARRETT COUNTY MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death OAKLAND | | | | 4c. County of Death GARRETT | | |
| Funeral Director | 5. Social Security Number 187-20-0189 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth Month Day Year MAY 28, 1927 | | 9. Birthplace (State or Foreign Country) PA | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County GARRETT | | 10c. City, Town or Location SWANTON | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 538 YACHT CLUB ROAD | | | | 10f. Zip Code 21561 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BUSINESS MANAGER | | | | 16b. Kind of Business/Industry LUMBER YARD | | | |
| 17. Father's Name (First, Middle, Last) EDWARD GILBERT WETZEL, SR. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) HELEN PARKER | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ELLEN F. WETZEL - WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 538 YACHT CLUB ROAD SWANTON, MD 21561 | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) OMEGA CREMATORY | | 20c. Date 8/6/99 | | 20d. Location - City or Town, State MORGANTOWN, WV | | | |
| 21. Signature of Funeral Service Licensee  MOO167 | | | | 22. Name and Address of Facility P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CORONARY VASCULAR DISEASE Due to (or as a consequence of): | | | | | | | | | | 1 HOUR | |
| Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): | | | | | | | | | | | |
| c. Due to (or as a consequence of): | | | | | | | | | | | |
| d. Due to (or as a consequence of): | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  | | | | 29c. License number H26154 | | 29d. Date signed (Month, Day, Year) AUGUST 5, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. DANIEL MILLER, D.O. 69 WOLF ACRES DRIVE OAKLAND, MD 21550 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG - 9 1999 | | | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

10/10/1944

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26739

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary C. Wade | | | | 2. Date of Death Month August Day 11 Year 1999 | | 3. Time of Death 8:11am | |
| | 4a. Facility Name (If not institution, give street and number) CIVISTA Medical Center | | | | 4b. City, Town, or Location of Death LaPlata | | 4c. County of Death Charles | |
| Funeral Director | 5. Social Security Number 213-38-6227 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 60 Yrs. | | 8. Date of Birth (Month, Day, Year) February 15, 39 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Charles | | 10c. City, Town or Location Waldorf | |
| To Be Completed by Funeral Director | Usual Residence of Decedent 15096 Hoffman Rd | | | | 10f. Zip Code 20601 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Education Teacher | | 16b. Kind of Business/Industry Charles County Bd OF Education | | | |
| | 17. Father's Name (First, Middle, Last) Edward Charms | | | | 18. Mother's Name (First, Middle, Maiden Surname) Inez Chase | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Donald Wade /Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15096 Hoffman Rd, Waldorf Maryland 20601 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Marys Cath. Ch | | Date Aug. 14, 99 | | 20c. Location - City or Town, State Bryantown Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility ADAMS FUNERAL HOME .P.A. AQUASCO MD20608 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Asthma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death 38y |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how Injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | 29b. Signature and title of certifier |
| | 29c. License number D0052533 | | 29d. Date signed (Month, Day, Year) 11 Aug 99 | | 29e. Date signed (Month, Day, Year) 11 Aug 99 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela Fowler-Brown M.D., SA, 804 MDOS/SGEP, 1043 Boston St. Andrews AFB MD | | | | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela Fowler-Brown M.D., SA, 804 MDOS/SGEP, 1043 Boston St. Andrews AFB MD |
| | 31. Date filed (Month, Day, Year) AUG 13 1999 | | 32. Registrar's Signature | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26740

| | | | | | | | | |
|--|--|---|--|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EUGENE BUTLER | | | | 2. Date of Death Month Day Year August 24 1999 | | 3. Time of Death 11:10 pm | |
| | 4a. Facility Name (If not institution, give street and number) Maryland General Hospital | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 218-05-0599 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 08/14/1914 | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 110 W. 20TH STREET | | | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER | | 16b. Kind of Business/Industry CONSTRUCTION | | |
| 17. Father's Name (First, Middle, Last) HARRY BUTLER | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARY CROSBY | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JACQUELINE LANDON/NIECE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1423 WISP CT. HANOVER, MD. 21076 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT ZION | | Date 8/30/99 | | 20c. Location - City or Town, State Balto., MD | | |
| 21. Signature of Funeral Service Licensee <i>James A. Morton</i> | | | | 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST. BALTO., MD. 21217 | | | | |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Adult Respiratory Distress Syndrome Due to (or as a consequence of): b. Systemic Inflammatory Response Syndrome Due to (or as a consequence of): c. Hypercalcemia Due to (or as a consequence of): d. Renal Failure | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Chandok</i> | | 29c. License number 89346 | | 29d. Date signed (Month, Day, Year) 8/25/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arun Chandok, M.D. 60 Maryland General Hospital | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | 32. Registrar's Signature <i>James B. Sparks</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26741

AMENDED ITEM#23a PER MD G775 9/24/99 AH

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

ALLEAN B. BRIGHTMAN

2. Date of Death

Month Day Year
AUGUST 25 1999

3. Time of Death

4:00 AM

4a. Facility Name (If not institution, give street and number)

PIKESVILLE NURSING & CONVALESCENT CTR.

4b. City, Town, or Location of Death

PIKESVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

463-86-7154

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 20, 1910

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Pikesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

505 1/2 Sudbrook Ln

10f. Zip Code

21208

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Public Schools

17. Father's Name (First, Middle, Last)

Jessie Alford Bettis

18. Mother's Name (First, Middle, Maiden Surname)

Dalah Texas Eoof

19a. Informant's Name/Relationship (Type, Print)

Berta Brightman/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

505 1/2 Sudbrook Ln Baltimore, MD 21208

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

8-26-99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Stephen D. Lohrmann

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Alzheimer's Disease* DEMENTIA

Due to (or as a consequence of):

b. HYPONATREMIA

Due to (or as a consequence of):

c. ANEMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Raymond Miller MD

29c. License number

D 47683

29d. Date signed (Month, Day, Year)

8/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raymond Miller 25 Main Street Suite 200 Pikesville MD

21134

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

Raymond Miller

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

[Illegible body text]

IT IS THE POLICY OF THE FBI TO

[Illegible body text]

99-4964-510

B.K.S

GLADYS BRISTOW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26742

| | | | | | | | | | | |
|---|--|---|---|---|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Gladys L. Bristow | | | | | 2. Date of Death Month Day Year AUG. 21, 1999 | | 3. Time of Death 1804 PM | | |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL E.R. | | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | | |
| Funeral Director | 5. Social Security Number 218-26-8785 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 67 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 05 09 32 | | 9. Birthplace (State or Foreign Country) S.C. | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 5252 St. Charles Ave | | | | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) na | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian | | | 16b. Kind of Business/Industry School | | | |
| 17. Father's Name (First, Middle, Last) Nebraska Bristow | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Jackson | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Erwin House-Son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3902 Edgewood Rd, Baltimore Md 21215 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | Date 8/28/99 | | 20c. Location - City or Town, State Randallstown, Md | | | |
| 21. Signature of Funeral Service Licensee <i>Shannon Stokes</i> | | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? INSPECTION <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Kenneth J. Sparks MD</i> | | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) AUG. 22, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYDORON A. KORTH 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year) AUG 26 1999 | | 32. Registrar's Signature <i>Kenneth J. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26743

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Howard Theodore Braecklein | | | | 2. Date of Death Month Day Year August 24 1999 | | 3. Time of Death 9:10 am | |
| | 4a. Facility Name (If not institution, give street and number) St. Agnes Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death n/a | |
| Funeral Director | 5. Social Security Number 215-05-0827 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) October 18, 1918 | |
| | Usual Residence of Decedent | | 10a. State Maryland | | 10b. County n/a | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 1143 Linden Avenue | | 10f. Zip Code 21227 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (14 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) scheduling department worker | | 16b. Kind of Business/Industry Mass Transit Authority | | | |
| | 17. Father's Name (First, Middle, Last) Howard G. Braecklein | | | | 18. Mother's Name (First, Middle, Maiden Surname) Katherine Rahm | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Leroy A. Braecklein - nephew | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 Skyview Drive, Shrewsbury, Pennsylvania 17361 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | 20c. Location - City or Town, State Baltimore, Maryland | | 20d. Date 8/27/99 | |
| | 21. Signature of Funeral Service Licensee Ann Y. Zink | | | | 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, Maryland 21229 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Due to (or as a consequence of): Lung collapse (Atelectasis) Metastatic (Burkitt's-type) Non-Hodgkins Lymphoma - high grade. | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure, severe coronary artery disease, bronchial asthma. | | | | | | | |
| | 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier A. Ballat | | | | 29c. License number F-1190- | | 29d. Date signed (Month, Day, Year) August 24, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMAL BALLAT 900 Caton Avenue Baltimore, Maryland 21229 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 26 1999 | | | | 32. Registrar's Signature B. Sparks | | | |
| | State Registrar | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26744

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lester I. Boring, Sr.

2. Date of Death

August 23, 1999

3. Time of Death

9:12 AM

4a. Facility Name (If not institution, give street and number)

9630 Susies Way

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

205-01-0344

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
October 31, 1914

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Pennsylvania

10b. County

St. Clair

10c. City, Town or Location

Steward

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

P.O. Box 189; 10th & Hoover Street

10f. Zip Code

15954

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Steel Worker

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

Issac Boring

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Cochran

19a. Informant's Name/Relationship (Type, Print)

Ms. Dona Jo Zelensky

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1562 Rt. 56 Hwy. East Homer City, Pennsylvania 15748

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Bethel Cemetery

Date

08/27/99

20c. Location - City or Town, State

New Florence, Pennsylvania

21. Signature of Funeral Service Licensee

Kenneth A. Stuart Funeral Home
139 Ligonier Street New Florence, PA 15944

22. Name and Address of Facility

Kenneth A. Stuart Funeral Home
139 Ligonier Street New Florence, PA 1594423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Hypotension

Due to (or as a consequence of):

days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Ischemic Cardiomyopathy

Due to (or as a consequence of):

years

c. Metastatic Prostate CA

Due to (or as a consequence of):

months

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Kathleen M. York-Smith

29c. License number

D37011

29d. Date signed (Month, Day, Year)

8-23-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

York-Smith, Kathleen M., M.D. 9501 Old Annapolis Road Ellicott City, MD 21043

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

granddaughter
house

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26745

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frances K. Clocker

2. Date of Death

Month Aug. 22, Day 1999 Year

3. Time of Death

1:23 PM

4a. Facility Name (If not institution, give street and number)

Manor Care Towson

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

213-20-5182

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 27, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

509 East Joppa Road

10f. Zip Code

21286

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Office Administrator

16b. Kind of Business/Industry

State Welfare Dept.

17. Father's Name (First, Middle, Last)

Francis H. Kues

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Wambaugh

19a. Informant's Name/Relationship (Type, Print)

Patricia McComas/Guardian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

915 Breezewick Circle Towson, Maryland 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Most Holy Redeemer Cem.

Date

8/28/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)e. Chronic Bronchitis
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Coronary artery disease
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

542736

29d. Date signed (Month, Day, Year)

8-24-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ayman F. Akkad, M.D. 7600 Osler Dr. Suite 203 Towson, Md. 21204

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26746

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harold V. Davis | | | | 2. Date of Death Month Day Year AUGUST 21, 1999 | | 3. Time of Death 0926 AM | |
| | 4a. Facility Name (If not institution, give street and number) 911 WEST LOMBARD STREET | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 228-58-4051 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 54 Yrs. | | 8. Date of Birth (Month, Day, Year) June 29, 1945 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State Maryland | | 10b. County N/A | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 911 W. Lombard St. | |
| | 10f. Zip Code 21223 | | | | 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | |
| To Be Completed by Physician/Medical Examiner | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Afro-American | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian | | 16b. Kind of Business/Industry School System | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Beverly Davis Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Maude Johnson | | | |
| | 19a. Informant's Name/Relationship (Type, Print) (Sister) Mrs. Dorothy Ross | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2220 Ashburton St. Balto, Md. 2 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion | | 20c. Location - City or Town, State 8/26/99 Lansdowne, Md. | |
| | 21. Signature of Funeral Service Licensee Joseph L. Russ | | | | 22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216 | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) s. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus, ASTHMA | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? INSPECTION <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at this time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | 29b. Signature and title of certifier Dennis J. Chute M.D. | |
| | 29c. License number O.C.M.E. | | | | | | 29d. Date signed (Month, Day, Year) AUGUST 25, 1999 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | 31. Date filed (Month, Day, Year) AUG 26 1999 | |
| | 32. Registrar's Signature G. Sparks | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26747

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Guilbert Daley

2. Date of Death

August 23, 1999

3. Time of Death

14:30

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

579-26-9710

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 31, 1923

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4417 Elderon Ave.

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

College Professor

16b. Kind of Business/Industry

State College

17. Father's Name (First, Middle, Last)

Charles Daley

18. Mother's Name (First, Middle, Maiden Surname)

Mary Gilbert

19a. Informant's Name/Relationship (Type, Print) (wife)

Mrs. Thelma Daley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4417 Elderon Ave, Balto, Md. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cem.

Date

8/28/99

20c. Location - City or Town, State

Balto, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracranial Hemorrhage

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check Only)

1 ☒ Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michele D. Mennette

29c. License number

P13216

29d. Date signed (Month, Day, Year)

August 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michele D. Mennette M.D. 2401 W. Belvedere Ave. 21215

State
Registrar

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

B. Sparks

Patient Known As: Guilbert Daley

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

JUN 28 1964

Shirley Louise Fisher

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G774 8-27-99

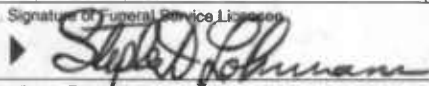
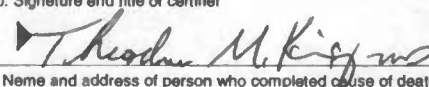
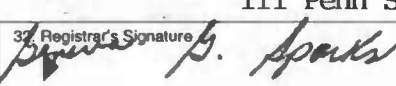
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26748

| | | | | | | | | | | |
|---|--|---|--|---|--|--|--------------------------------|---|--------------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Shirley Louise Fisher | | | | 2. Date of Death Month Day Year August 18, 1999 | | | | 3. Time of Death 1:30 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 1421 Broening Highway | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 215-30-2476 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 64 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) Feb. 2, 1935 | | 9. Birthplace (State or Foreign Country) Maryland | | Usual Residence of Decedent | | 10e. State MD | | 10b. County N/A | |
| 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 1421 Broening Hwy | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) College | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Domestic | | 17. Father's Name (First, Middle, Last) Roy Ernest Snyder | | 18. Mother's Name (First, Middle, Maiden Surname) Grace Louise Murray | | 19. Informant's Name/Relationship (Type, Print) Norman Snyder/Brother | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory | | 20c. Date 8-23-99 | | 20d. Location - City or Town, State Baltimore, MD | | 21. Signature of Funeral Service Licensee  | | |
| 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ALCOHOL AND NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) FOUND: 8-18-1999 | | 28b. Time of Injury FOUND: 1:24 | | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred UNKNOWN | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) RESIDENCE | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1421 BROENING HIGHWAY, BALTIMORE, MD. | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) August 18, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING | | 31. Date filed (Month, Day, Year) AUG 26 1999 | | 32. Registrar's Signature  | | 33. Registrar's Name 111 Penn Street, Baltimore, Maryland 21201 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

THE JOURNAL OF THE

1909

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26749

| | | | | | | | | |
|---|--|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Charles G. Fitzhugh, Sr. | | | | 2. Date of Death Month Day Year August 24, 1999 | | 3. Time of Death 11:00 PM | |
| | 4a. Facility Name (If not institution, give street and number) 6410 Walther Avenue | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 216-14-7807 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 4, 1914 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 6410 Walther Avenue | | 10f. Zip Code 21206 | | |
| 10g. Citizen of What Country? United States | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security Guard | | 16b. Kind of Business/Industry Pinkerton | | |
| 17. Father's Name (First, Middle, Last) Charles H. Fitzhugh | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ethel Blain | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Edna Saynuk / Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 622 S. Port Street Baltimore, MD 21224 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gardens 8/28/99 Timonium, Maryland | | 20c. Location - City or Town, State | | | | |
| 21. Signature of Funeral Service Licensee Timothy Harman | | | | 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. prostate cancer metastatic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Daniel Laheru MD | | | | 29c. License number D0053070 | | 29d. Date signed (Month, Day, Year) Aug. 25, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Daniel Laheru 600 N. Wolfe Street Baltimore, MD 21205 Oncology Center | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | | | 32. Registrar's Signature B. Sparks | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26750

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) William Frederick Gardner, Jr. | | | | 2. Date of Death Month Day Year AUGUST 24, 1999 | | 3. Time of Death 7:19 PM | |
| | 4a. Facility Name (If not Institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 500-38-4047 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 60 Yrs. | | 8. Date of Birth (Month, Day, Year) SEP 5, 1938 | |
| | 9. Birthplace (State or Foreign Country) Missouri | | 10a. State Missouri | | 10b. County Jasper | | 10c. City, Town or Location Jasper | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 211 N. Main Street | | 10f. Zip Code 64755 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 1955/ If Yes, Give Year or Dates: 1963 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook | | 16b. Kind of Business/Industry Restaurant | | | |
| | 17. Father's Name (First, Middle, Last) William Frederick Gardner, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Virginia M. Johnson | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Donald C. Gardner, Sr./brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 N. Main Street, Jasper, MO 64755 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | 20c. Location - City or Town, State Baltimore, MD | | 20d. Date 08/26/99 | |
| | 21. Signature of Funeral Service Licensee Edward A. Gregorchik | | 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Physician /Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier John D. Martin | | 29c. License number D45019 | | 29d. Date signed (Month, Day, Year) Aug 26, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN D. MARTIN 104 FORBES STREET ANNAPOLIS | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 26 1999 | | 32. Registrar's Signature L. B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26751

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT

LEE

S.

HYMAN

2. Date of Death

Month

Day

Year

3. Time of Death

14:55

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-10-9505

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG. 1, 1920

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6320 GREENSPRING AVENUE #106

10f. Zip Code

21209

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALESPERSON

16b. Kind of Business/Industry

WHOLESALE LIQUOR

17. Father's Name (First, Middle, Last)

CALVIN

18. Mother's Name (First, Middle, Maiden Surname)

ROSE

SAGNER

19a. Informant's Name/Relationship (Type, Print)

ALBERTA HYMAN / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6320 GREENSPRING AVE. #106 - BALTIMORE, MD 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHIZUK AMUNO ARLINGTON

Date

8/26/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Multisystem Organ Failure

72 hr

a.

Due to (or as a consequence of):

Sepsis

7 days

b.

Due to (or as a consequence of):

Hematuria

14 days

c.

Due to (or as a consequence of):

Transitional Cell Carcinoma of Bladder

1 month

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P09785

29d. Date signed (Month, Day, Year)

08/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah Glassman, 2401 W. Belvedere Ave., Baltimore, Md. 21215

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

B. Sparks

State Registrar

Patient Known As: Robert Hyman
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

AH 5+1

WRC
99-4947-510
WALTER
HORN JR.
AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G775 9-10-99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26752

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Walter D. Horn, Jr.

2. Date of Death

Month Day Year
AUGUST 21, 1999

3. Time of Death

4:02 PM.

4a. Facility Name (If not institution, give street and number)

604 S. MONROE ST.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

218-02-9781

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

19 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jul 4, 1980

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland n/a

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

604 South Monroe Street

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Abestos Remover

16b. Kind of Business/Industry

Cons.

17. Father's Name (First, Middle, Last)

Walter D. Horn, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Emily M. LeJune

19a. Informant's Name/Relationship (Type, Print)

Joannie C. Horn / Step-mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

604 South Monroe Street, Baltimore, Maryland 21223

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Mausoleum

Date

8/27/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hubbard Funeral Home, Inc.
4107 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

METHADONE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☒ Could not be determined

28a. Date of Injury (Month, Day Year)

Found: 8-21-99

28b. Time of Injury

Found: 3:55 P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

FOUND: RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

604 S. MONROE ST
BALTIMORE, MARYLAND

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Wayne Mitchell MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARRY SMITH A. KORN 111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

SEP 9 1999

32. Registrar's Signature

Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1-100-1-100-1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26753

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Norma Loretta Harris

2. Date of Death

August 24 1999

3. Time of Death

2:35PM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

220-36-6777

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11-29-1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3412 Duvall Ave.

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Foster Parent

16b. Kind of Business/Industry

Foster Care
State Of Maryland

17. Father's Name (First, Middle, Last)

Albert McDuffie

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Lee

19a. Informant's Name/Relationship (Type, Print)

Shirley D.M.Harris -Wms. (Daughter) 3412 Duvall Ave. Balto., Md. 21216

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

8/28/99

20c. Location - City or Town, State

Landsdowne, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Caple Funeral Service

5502 Winner Ave. Balto., Md. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

P12337

29d. Date signed (Month, Day, Year)

August 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASIF RAFI

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

[Signature]

State
Registrar

77 Known as Norma Harris
Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26754

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George Joseph Hallameyer

2. Date of Death

August 23, 1999

Day Year

3. Time of Death

9:55 PM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

214-05-3274

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 28, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3325 Shannon Drive

10f. Zip Code

21213

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sheet Metal Mechanic

16b. Kind of Business/Industry

Aerospace Defense

17. Father's Name (First, Middle, Last)

Frederick Hallameyer

18. Mother's Name (First, Middle, Maiden Surname)

Edna Stallings

19a. Informant's Name/Relationship (Type, Print)

Christine B. Hallameyer (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3325 Shannon Drive, Baltimore, Maryland 21213

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

8/25/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home Inc.

3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure
Due to (or as a consequence of):b. ASCVD, COPD
Due to (or as a consequence of):c. Coronary Insufficiency
Due to (or as a consequence of):

d. Cardiac Arrhythmias

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

M.D. 200-383

29d. Date signed (Month, Day Year)

8/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARLOS E. ARANOA, MD. 3007-E NORTHERN PARKWAY, BALTO MD 21214

31. Date filed (Month, Day Year)

AUG 26 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26755

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

TILLIE AGNES HEINE

2. Date of Death
Month Day Year
August 24, 19993. Time of Death
8:45 a.m.

4a. Facility Name (If not institution, give street and number)

1200 Dranmore Way

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

215-54-3501

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Feb. 16, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1200 Dranmore Way

10f. Zip Code

21014

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Owner/Operator

16b. Kind of Business/Industry

Grocery Store

17. Father's Name (First, Middle, Last)

Francis Janda

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Sola

19a. Informant's Name/Relationship (Type, Print)

Mildred Harrison (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1200 Dranmore Way, Bel Air, MD. 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Most Holy Redeemer Cem.

Date

8/27/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.

610 W. MacPhail Road, Bel Air, MD. 21014

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic renal Failure

Due to (or as a consequence of):

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Nephrosclerosis

Due to (or as a consequence of):

2 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D20673

29d. Date signed (Month, Day, Year)

8/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brose, Lawrence 7672 Belair MD Bel Air, MD 21038

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26756

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE LOUIS HESS

2. Date of Death

Month Day Year
AUGUST 24, 1999

3. Time of Death

11:30 a.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

STELLA MARIS HOSPICE

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

219-28-4814

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
APRIL 3, 1930

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

PENN.

10b. County

YORK

10c. City, Town or Location

RED LION

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

175 WIMBLETON WAY

10f. Zip Code

17356

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ENGINEER

16b. Kind of Business/Industry

WESTINGHOUSE

17. Father's Name (First, Middle, Last)

CHARLES HESS

18. Mother's Name (First, Middle, Maiden Surname)

KATHLEEN HUNTLEY

19a. Informant's Name/Relationship (Type, Print)

SUSAN WOLLENWEBER (STEP-DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

319 KENNARD AVENUE, EDGEWOOD, MD. 21040

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DULANEY VALLEY MEM. GARDENS 8/26/99 TIMONIUM, MARYLAND

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SCHIMUNEK FUNERAL HOME OF BEL AIR, INC.

610 W. MACPHAIL ROAD, BEL AIR, MD. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. LYMPHOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD - 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

D. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

GEORGE HESS AUGUST 24, 1999 11:30 a.m.

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26757

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ISAIAH D. HILL

2. Date of Death

Month Day Year
AUGUST 22, 1999

3. Time of Death

1:08 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

BALTIMORE

5. Social Security Number

219-28-0699

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JAN 6 1934

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8413 MERRYMOUNT DRIVE

10f. Zip Code

21244

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 52/56

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12 yrsCollege (1-4 or 5+)
2 yrs16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

PASTOR

16b. Kind of Business/Industry

MINISTRY

17. Father's Name (First, Middle, Last)

SOLOMON K HILL

18. Mother's Name (First, Middle, Maiden Surname)

SALLY ANN BRIGGS

19a. Informant's Name/Relationship (Type, Print)

Ernestine Hill/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8413 Merrymount Drive, Baltimore Maryland 21244

20a. Method of Disposition

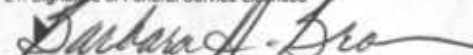
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GARRISON FOREST

Date

8-27-99 OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

WILLIAM C BROWN COMMUNITY FUNERAL HOME PA
1206 W NORTH AVENUEPhysician
/Medical
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CORONARY ARTERY DISEASE

20 YEARS

Due to (or as a consequence of):

b. MORBID OBESITY

20 YEARS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 MD

29c. License number

D0054702

29d. Date signed (Month, Day, Year)

8/22/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NONA NOVELLO MD 9000 FRANKLIN SQ. DR. BALTO, MD 21237

State
Registrar

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature



ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Items#25,27 28a-f per PhyG774 8/25/99 EW

Certificate of Death

Reg. No.

99 26758

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Timothy

2. Date of Death

July 17 1999

3. Time of Death

20:30

4a. Facility Name (If not institution, give street and number)

THE Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore, City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

148-18-0758

6. Sex

M 2 F

7. Age (In yrs. last birthday)

73

8. Date of Birth (Month, Day, Year)

April 23, 1926

9. Birthplace (State or Foreign Country)

NJ

Usual Residence of Decedent

10a. State

NJ

10b. County

Monmouth

10c. City, Town or Location

Sea Girt

10d. Inside City Limits

Yes 2 No

10e. Street and Number

1113 Hemlock Avenue

10f. Zip Code

08750

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes 2 No 3 If Yes, Give Year or Dates: Unk.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4or 5+) 0

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Postal Clerk

16b. Kind of Business/Industry

Post Office

17. Father's Name (First, Middle, Last)

Francis Herlihy

18. Mother's Name (First, Middle, Maiden Surname)

Florence Stringer

19a. Informant's Name/Relationship (Type, Print)

Marie Herlihy / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1113 Hemlock Avenue, Sea Girt, NJ 08750

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

July 21, 1999

20c. Location - City or Town, State

Baltimore City

21. Signature of Funeral Service Licensee

Victor P. Doda, Jr.

22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Traumatic subarachnoid hemorrhage

ten days

Due to (or as a consequence of):

b. Skull Fracture

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

July 5, 1999

28b. Time of Injury

12:30 PM

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

fell down steps to sidewalk

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Water St, St George, Bermuda

29a. Certifier (Check only one)

1 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Amer Samdani

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

July 17, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Amer Samdani, Johns Hopkins Hospital

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

3-22-64

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26759

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GARY L.

HODGSON

2. Date of Death
Month Day Year
AUGUST 22 19993. Time of Death
18:27

4a. Facility Name (If not institution, give street and number)

THE Johns Hopkins Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

538-60-4777

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
05/13/1955

9. Birthplace (State or Foreign Country)

Washington

Usual Residence of Decedent

10a. State

PA

10b. County

Lancaster

10c. City, Town or Location

Lancaster

10d. Inside City Limits

1□ Yes 2XX No

10e. Street and Number

755 Dustin Drive

10f. Zip Code

17601

10g. Citizen of What Country?

United States

11. Marital Status

1□ Never Married 2X Married
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1□ Yes 2X No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2X No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Repairman

16b. Kind of Business/Industry

Air Conditioning

17. Father's Name (First, Middle, Last)

Howard V. Hodgson

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Hallett

19a. Informant's Name/Relationship (Type, Print)

Mrs. Marie Hodgson / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

755 Dustin Drive Lancaster, PA 17601

20a. Method of Disposition

1□ Burial 2X Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Evans Crematory

Date

08/24/99

20c. Location - City or Town, State

Leola, PA

21. Signature of Funeral Service Licensee

Stephen D. Coster

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Road Towson, Maryland 2120423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. SEPSIS (GRAM-NEGATIVE)

Due to (or as a consequence of):

5 WEEKS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. BILIARY LEAK

Due to (or as a consequence of):

3 WEEKS

c. LIVER TRANSPLANT

Due to (or as a consequence of):

11 WEEKS

d. LIVER FAILURE DUE TO HEPATITIS C

Due to (or as a consequence of):

3 MONTHS

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE Renal Failure

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2X No 3□ Probably 4□ Unknown

24a. Was an autopsy
performed?

1□ Yes 2X No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1□ Yes 2X No

25. Was case referred to medical
examiner?

1□ Yes 2X No

Hospital:

1X Inpatient

2□ ER/Outpatient

3□ DOA

26. Place of Death (Check only one)

Other:

4□ Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1X Natural 5□ Pending
Investigation
2□ Accident 6□ Could not be
determined
3□ Suicide
4□ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Jolanda Zickmann, MD

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

AUGUST, 22 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOLANDA ZICKMANN 600 NORTH WOLFE STREET BALTIMORE, MD 21287-9106

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-358-2025.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26760

AMEND #10e PER F.H. G774 8-31-99 J.A.

| | | | | | | | | | | | | | | | |
|--|---|---------------------------------|---|---|--|---|------------------|---|--|--------------------------------|----------------|-------------------------------|----------------|----|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CATHERINE JUKNELIS | | 2. Date of Death Month Day Year AUGUST 26, 1999 | | 3. Time of Death 03:18AM | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 217-64-6956 | 6. Sex 1 M 2 F | 7. Age (In yrs. last birthday) 46 Yrs. | 8. Date of Birth (Month, Day, Year) FEB 7, 1953 | 9. Birthplace (State or Foreign Country) Ohio | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Baltimore | 10c. City, Town or Location Catonsville | | 10d. Inside City Limits 1 Yes 2 No | | | | | | | | | | |
| | 10e. Street and Number 1201 BIDDLE PLACE 1202 BIDDLE PLACE | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? USA | | | | | | | | | | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | | | | | | | | | |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Assistant | | 16b. Kind of Business/Industry Physician's Office | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Max Randolph | | 18. Mother's Name (First, Middle, Maiden Summa) Mary Jane McNeff | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) James A. Juknelis/husband | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1201 Biddle Place Catonsville, MD 21228 | | | | | | | | | | | | |
| | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 08/26/99 | | 20c. Location - City or Town, State Baltimore, MD | | | | | | | | | | |
| Physician /Medical Examiner | 21. Signature of Funeral Service Licensee Edward A. Gregorchik | | 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. UREMIA</td> <td>Approximate Interval Between Onset and Death 3 days</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. HEPATORENAL SYNDROME</td> <td>2 WEEKS</td> </tr> <tr> <td>c. ALCOHOLIC CIRRHOSIS</td> <td>5 YEARS</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | Immediate Cause (Final disease or condition resulting in death) | a. UREMIA | Approximate Interval Between Onset and Death 3 days | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. HEPATORENAL SYNDROME | 2 WEEKS | c. ALCOHOLIC CIRRHOSIS | 5 YEARS | d. | |
| | Immediate Cause (Final disease or condition resulting in death) | a. UREMIA | Approximate Interval Between Onset and Death 3 days | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. HEPATORENAL SYNDROME | 2 WEEKS | | | | | | | | | | | | | |
| | c. ALCOHOLIC CIRRHOSIS | 5 YEARS | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | | | | | | | | | | | |
| | 24a. Was an autopsy performed? 1 Yes 2 No | | | | | | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | | | | | | | | | | | |
| | 25. Was case referred to medical examiner? 1 Yes 2 No | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | | | | | | |
| | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | | | | | | | | | | | |
| | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | | | | | | | | | | | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | |
| | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | |
| | 29b. Signature and title of certifier David E. Kaplan MD | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) August 26, 1999 | | | | | | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID E. KAPLAN, MD; 600 N. WOLFE ST. TOWER 110; BALTIMORE, MD 21287 | | | | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 26 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26761

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Diamond Johnson-Anderson

2. Date of Death

08 23 1999 7:45 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

8610 Bramble Lane #101

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore County

5. Social Security Number

217-45-4598

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

3 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 23, 1995

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8610 Bramble Lane #101

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

0

Collage (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Karl Anderson

18. Mother's Name (First, Middle, Maiden Surname)

Candida Johnson

19a. Informant's Name/Relationship (Type, Print)

Candida Johnson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8610 Bramble Lane Randallstown, MD 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

King Memorial Park

Date

8/26/99

20c. Location - City or Town, State

Randallstown, MD

21. Signature of Funeral Service Licensee

Carol March

22. Name and Address of Facility

Cary P. March Funeral Home PA
270 Freephilton Buss Balt. MD 2122923a. Part I. Under the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Hypoxia, pulmonary hypertension
Due to (or as a consequence of):b. pneumonia
Due to (or as a consequence of):c. Chronic lung disease
Due to (or as a consequence of):

d. Chronic aspiration pneumonia

Approximate
Interval Between
Onset and Death

2 days

3 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

failure to thrive, steroid dependence,
ichthyosis of the skin, developmental
delay

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicida 4 ☐ Homicida28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Charlotte Glicksman MD

29c. License number

D47H28

29d. Date signed (Month, Day, Year)

8/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charlotte Glicksman MD, 2401 W. Belvedere Ave, Balt MD 21215

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
order.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26762

ANNA KNEAUEL
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | | | |
|---|--|--|---|---|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Anna M. Kneavel | | | | 2. Date of Death Month 8 Day 23 Year 99 | | | | 3. Time of Death 9:53 AM | | |
| | 4a. Facility Name (If not institution, give street and number) St. Elizabeth Nursing Home | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/a | | |
| Funeral Director | 5. Social Security Number 215-07-1143 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 95 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 4, 1904 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 4037 Wilkens Avenue, | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Collage (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Binder | | | | 16b. Kind of Business/Industry Business Form Co. | | | |
| 17. Father's Name (First, Middle, Last) George W. Stallings | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sarah Richard | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Roxie L. Atkinson / Personal Rep. | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4037 Wilkens Avenue, Baltimore, Maryland 21229 | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | | | 20c. Location - City or Town, State 8/24 Baltimore, Maryland | | | |
| 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Parkinson's disease</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | | | | Approximate Interval Between Onset and Death years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Urinary tract infection</u> <u>Degenerative joint disease</u> | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier <u>Benjamin S. Lee M.D.</u> | | | | | | 29c. License number D52544 | | 29d. Date signed (Month, Day, Year) Aug 23, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin S. Lee, M.D., 500 N. Rolling Road, Suite 4, Catonsville, MD 21228 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) Aug - 26 1999 | | | | 32. Registrar's Signature <u>Benjamin S. Sparks</u> | | | | | | | |

AA15

MA 52-8 25 2

UNIV KRIEGER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26763

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Irvin Leonard Koerner

2. Date of Death

August 22, 1999

3. Time of Death

1:45 PM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-05-4082

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 9, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8800 Walther Blvd., Apt. 3616

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Office Worker

16b. Kind of Business/Industry

Gas & Electric Utility Company

17. Father's Name (First, Middle, Last)

George Koerner

18. Mother's Name (First, Middle, Maiden Surname)

Marie Lergenmiller

19a. Informant's Name/Relationship (Type, Print)

Mrs. Agnes A. Koerner (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8800 Walther Blvd., Apt. 3616, Balt., MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer Cem.

Date

8/26/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

► Mark T. [Signature]

22. Name and Address of Facility

Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sudden

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► [Signature]

29c. License number

D20673

29d. Date signed (Month, Day, Year)

8/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Lowe MD 7672 Belair Rd Baltimore, MD 21236

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

cm

Luke Tyler Kobal

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO *Certificate of Death*

Certificate of Death

Reg. No. 99 26764

99 26764

| | | | | | | | | | | | |
|--|---|---|--|---|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LUKE TYLER KOBAL | | | | | | 2. Date of Death Month Day Year August 23, 1999 | | | 3. Time of Death 5:50 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 3347 Garrison Circle | | | | | | 4b. City, Town, or Location of Death Abingdon | | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 214-55-0574 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. Months Days 4 2 | | 8. Date of Birth (Month, Day, Year) April 21, 1999 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD. | | 10b. County Harford | | 10c. City, Town or Location Abingdon | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 3347 Garrison Circle | | | | | | 10f. Zip Code 21009 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A | | | | 16b. Kind of Business/Industry N/A | | | |
| 17. Father's Name (First, Middle, Last) Timothy Andrew Kobal | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Maureen Susan McManus | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Maureen S. Kobal (Mother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3347 Garrison Circle, Abingdon, MD. 21009 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardens | | Date 8/28/99 | | 20c. Location - City or Town, State Bel Air, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS COMPLICATING ARTHROGRYPOSIS MULTIPLEX a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) August 24, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore M. King 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | | | 32. Registrar's Signature | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26765

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Booker Thomas Lawton

2. Date of Death
Month Day Year
August 20, 19993. Time of Death
10:00am

4a. Facility Name (If not institution, give street and number)

Chesapeake Hospice

4b. City, Town, or Location of Death

Linthicum

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

189-16-6484

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug 08, 1918

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

750 Annapolis Neck Road

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

10/27/41

08/26/43

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Pipe Tester

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

Eugene Lawton

18. Mother's Name (First, Middle, Maiden Surname)

Janie James

19a. Informant's Name/Relationship (Type, Print)

Valerie J. Lawton (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1656 Wadsworth Way Baltimore, Maryland 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Vet Cem 8/27/99 Owings Mills, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Caple Funeral Service

5502 Winner Avenue Baltimore, Maryland 21215

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. METASTATIC COLON CANCER

3 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Stuart E. Selovich

29c. License number

019838

29d. Date signed (Month, Day, Year)

August 25, 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Stuart E. Selovich, M.D. 900 BESTGATE RD Annapolis, MD 21401

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26766

| | | | | | | | | | | | | | | | | | | | | | | |
|--|--|----------------------------------|---|---|--|---|--|--|--|---|----|-------------------|----------------------------------|----|--|----------------------------------|----|--|----------------------------------|----|--|----------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ELINOR LINDEN | | | | 2. Date of Death Month 7 Day 31 Year 99 | | | | 3. Time of Death 9:25 PM | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Montgomery Village Nursing Home | | | | 4b. City, Town, or Location of Death Gaithersburg | | | | 4c. County of Death MONTGOMERY | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 529-54-9763 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) 10-17-08 | | 9. Birthplace (State or Foreign Country) HUNGARY | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County MONTGOMERY | | 10c. City, Town or Location Gaithersburg | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | |
| 10e. Street and Number 8005 EXODUS DRIVE | | | | 10f. Zip Code 20882 | | | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY | | | | 16b. Kind of Business/Industry CITY GOVERNMENT | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) ALIZAR HAVUS | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) VERA | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Phillip Lowe, Son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8005 EXODUS DRIVE, Gaithersburg, MD 20882 | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | | 20d. Date | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | | | 22. Name and Address of Facility State Anatomy Bd., BALTO. MD | | | | | | | | | | | | | | | | |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Arrhythmia</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Arrhythmia | Due to (or as a consequence of): | b. | | Due to (or as a consequence of): | c. | | Due to (or as a consequence of): | d. | | Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Arrhythmia | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | |
| | b. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | |
| | c. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | |
| | d. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration, Chronic pain syndrome | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | 29c. License number 842578 | | | | 29d. Date signed (Month, Day, Year) August 19, 1999 | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAIL CHATSKWIL, 11119 Rockville Pike #401, Rockville MD 20852 | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | | | 32. Registrar's Signature [Signature] | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26767

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Fred Laws | | | | 2. Date of Death Month AUGUST Day 22 Year 1999 | | | | 3. Time of Death 00:15 AM | | | |
| 4a. Facility Name (If not institution, give street and number) BON SECOUR HOSPITAL | | | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death | |
| 5. Social Security Number 248-52-4950 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 64 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) 11/19/1934 | |
| 9. Birthplace (State or Foreign Country) South Carolina | | | | | | | | | | | |
| Usual Residence of Decedent | | | | 10a. State Maryland | | | | 10b. County Baltimore | | | |
| 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 10e. Street and Number 35 S. Fulton Avenue | | | | 10f. Zip Code 21223 | | | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | |
| 16b. Kind of Business/Industry Construction | | | | 17. Father's Name (First, Middle, Last) Junius Laws | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lillian Boone | | | |
| 19e. Informant's Name/Relationship (Type, Print) Delores Laws / Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 S. Fulton Ave., Baltimore, Maryland 21223 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Prospect Hill Cemetery | | | | 20c. Location - City or Town, State 08/28/99 Towson, Maryland | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility The Derrick C. Jones Funeral Hm., 4611 Park Heights Ave., Baltimore, Maryland 21215 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed? Yes <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number OCME | | | | 29d. Date signed (Month, Day, Year) AUGUST 22, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mrs. Mary Ann D. Wilson 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | | | 32. Registrar's Signature | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26768

| | | | | | | | | |
|--|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOHN LOUIS LAGNA | | | | 2. Date of Death Month AUGUST Day 24 , Year 1999 | | 3. Time of Death 08:55 PM | |
| | 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 212-05-4962 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 16, 1907 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 4701 Mannasota Avenue | | | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant | | 16b. Kind of Business/Industry Baltimore Gas and Electric Co. | | | | |
| 17. Father's Name (First, Middle, Last) Frank Lagna | | | | 18. Mother's Name (First, Middle, Maiden Summa) Palmira Fassio | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Rose M. Lagna (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4701 Mannasota Avenue Baltimore, MD 21206 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus Cem. | | Data 8/27/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee  Michael E. Canapp | | | | 22. Name and Address of Facility LEONARD J. RUCK, INC. 5305 Harford Road Baltimore, MD 21214 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PNEUMONIA a. Due to (or as a consequence of): RESPIRATORY INSUFFICIENCY b. Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 2 WEEKS YEARS YEARS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier  Beatriz P. Dizon, M.D. | | | | | | |
| | | 29c. License number D 16492 | | 29d. Date signed (Month, Day, Year) August 24, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BEATRIZ P. DIZON, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | 32. Registrar's Signature  Barbara B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-26769

| | | | | | | | | |
|---|---|---|---|--|---|--|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Elizabeth M. Miller | | | | 2. Date of Death Month Day Year AUGUST 19, 1999 | | 3. Time of Death 1500PM | |
| | 4a. Facility Name (If not institution, give street and number) 1409 DEER PARK ROAD | | | | 4b. City, Town, or Location of Death FINKSBURG | | 4c. County of Death CARROLL | |
| Funeral Director | 5. Social Security Number 215-05-6976 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 82 Yrs. | 8. Date of Birth (Month, Day, Year) January 14, 1917 | 9. Birthplace (State or Foreign Country) Maryland | | | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Carroll | | 10c. City, Town or Location Finksburg | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 1409 Deer Park Road | | | | 10f. Zip Code 21048 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker | | 16b. Kind of Business/Industry Stove Company | | |
| 17. Father's Name (First, Middle, Last) Wendel Besser | | | | 18. Mother's Name (First, Middle, Maiden Surname) Amelia Koch | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary V. Harman/Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 623 S. Warwick Road Baltimore, Maryland 21229 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery | | Date 8/24/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Arteriosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? INSPECTION 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? XX Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 19, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMIALCEK 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | 32. Registrar's Signature  | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26770

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Howell Moore

2. Date of Death

Month Day Year
AUG 21 1999

3. Time of Death

11:26pm

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218-05-5746

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
05-10-15

9. Birthplace (State or Foreign Country)

BALTIMORE

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2301 BELAIR ROAD

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOUSEKEEPING

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH DAY

19a. Informant's Name/Relationship (Type, Print)

WILHERMIA MOORE, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1100 STODDARD CT, BALTIMORE, MD 21201

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MOUNT AUBURN

Date

8-28-99 BALTO. MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

William Howell

22. Name and Address of Facility

HOWELL FUNERAL HOME

4600 LIBERTY HIGHTS AVE, BALTO. MD 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

CEREBROVASCULAR ACCIDENT

a. Due to (or as a consequence of):

b. HYPERTENSION

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OBESITY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Harry M. Harris

29c. License number

D26880

29d. Date signed (Month, Day, Year)

8/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 Armon, Stace Balt. md. 21201, Harry M. Harris

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

James B. Sparks

State
Registrar

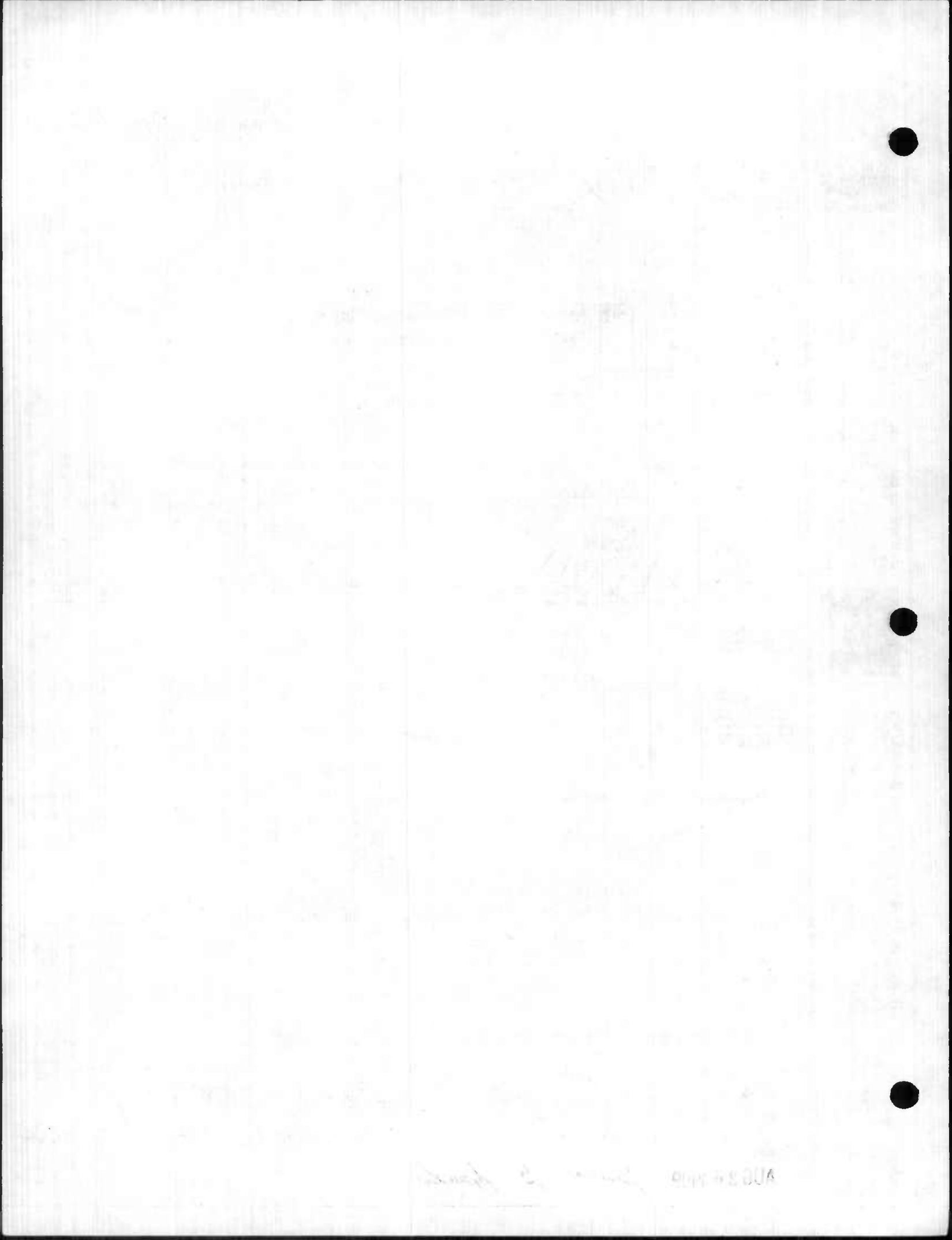
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26771

| | | | | | | | | | | |
|--|--|--|--|---|--|---|--------------------------------|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Eart Monroe</u> | | | | 2. Date of Death Month <u>August</u> Day <u>23</u> Year <u>1999</u> | | | | 3. Time of Death <u>8:00 A.M.</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>3409 N. Hilton Street</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | | | 4c. County of Death <u>NA</u> | |
| Funeral Director | 5. Social Security Number <u>219-01-0025</u> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>80</u> Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) <u>10 19 18</u> | | 9. Birthplace (State or Foreign Country) <u>M.D.</u> | | 10a. State <u>MD</u> | | 10b. County <u>NA</u> | | 10c. City, Town or Location <u>Baltimore</u> | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number <u>3409 North Hilton Road</u> | | 10f. Zip Code <u>21215</u> | | 10g. Citizen of What Country? <u>U.S.A.</u> | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>Black</u> | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>Unknown</u> College (1-4 or 5+) <u>na</u> | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Unknown</u> | | 16b. Kind of Business/Industry <u>Unknown</u> | | 17. Father's Name (First, Middle, Last) <u>McKinley Monroe</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Juanita Matthews</u> | | 19a. Informant's Name/Relationship (Type, Print) <u>Mildred Brown-Friend</u> | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3409 North Hilton Rd., Baltimore Md 21215</u> | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Mt. Zion Cemetery</u> | | 20c. Location - City or Town, State <u>8/28/99 Baltimore, Md</u> | | 21. Signature of Funeral Service Licensee <u>Shannon Spikes</u> | | |
| 22. Name and Address of Facility <u>March F/H West</u> | | 22a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Diabetic mellitus</u> Due to (or as a consequence of): <u>Coronary artery disease</u> Due to (or as a consequence of): <u>Peripheral Vascular disease</u> Due to (or as a consequence of): <u>Osteoarthritis</u> | | 22b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dysphagia</u> | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | |
| 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <u>[Signature]</u> | | 29c. License number <u>D30115</u> | | 29d. Date signed (Month, Day, Year) <u>8/23/99</u> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>T. Ohiokpehri, MD 2600 Liberty Herts Ave Baltimore MD 21215</u> | | |
| 31. Date filed (Month, Day, Year) <u>AUG 26 1999</u> | | 32. Registrar's Signature <u>[Signature]</u> | | 33. State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | 35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form. | | |

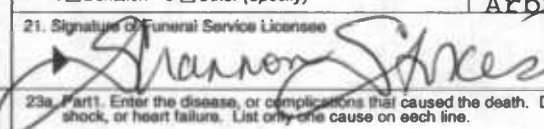
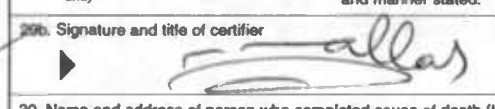
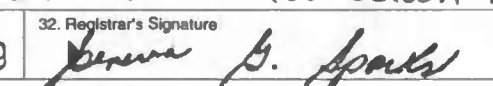
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26772

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Frank Moses | | | | 2. Date of Death Month Day Year August 24 1999 | | 3. Time of Death 10 45 | |
| | 4a. Facility Name (If not institution, give street and number) St Agnes Health care | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 249-14-0904 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) 03 28 16 | |
| | 9. Birthplace (State or Foreign Country) S.C. | | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 908 Mt. Holly Street | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th grade College (1-4 or 5+) na | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Worker | | 16b. Kind of Business/Industry Construction Co. | | | | |
| 17. Father's Name (First, Middle, Last) Nathaniel Moses | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Oliver | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Alleean Moses-Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 908 Mt. Holly Street, Baltimore Md 21229 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus memorial Park | | 20c. Date 8/28/99 | | 20d. Location - City or Town, State Arbutus, Md | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. pneumonia Due to (or as a consequence of): | | | | Day, | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Acute renal failure Due to (or as a consequence of): | | | | Day, | | |
| | | c. Congestive heart failure Due to (or as a consequence of): | | | | years | | |
| | | d. CVA Due to (or as a consequence of): | | | | years | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier  M.D. | | | | 29c. License number P12595 | | 29d. Date signed (Month, Day, Year) August-24-1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mustapha Mallah M.D 900 Caton Avenue, Baltimore, MD 21229 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | 32. Registrar's Signature  | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND: ITEM: #27, 28A-F PER MEO G774 8-24-99 WR

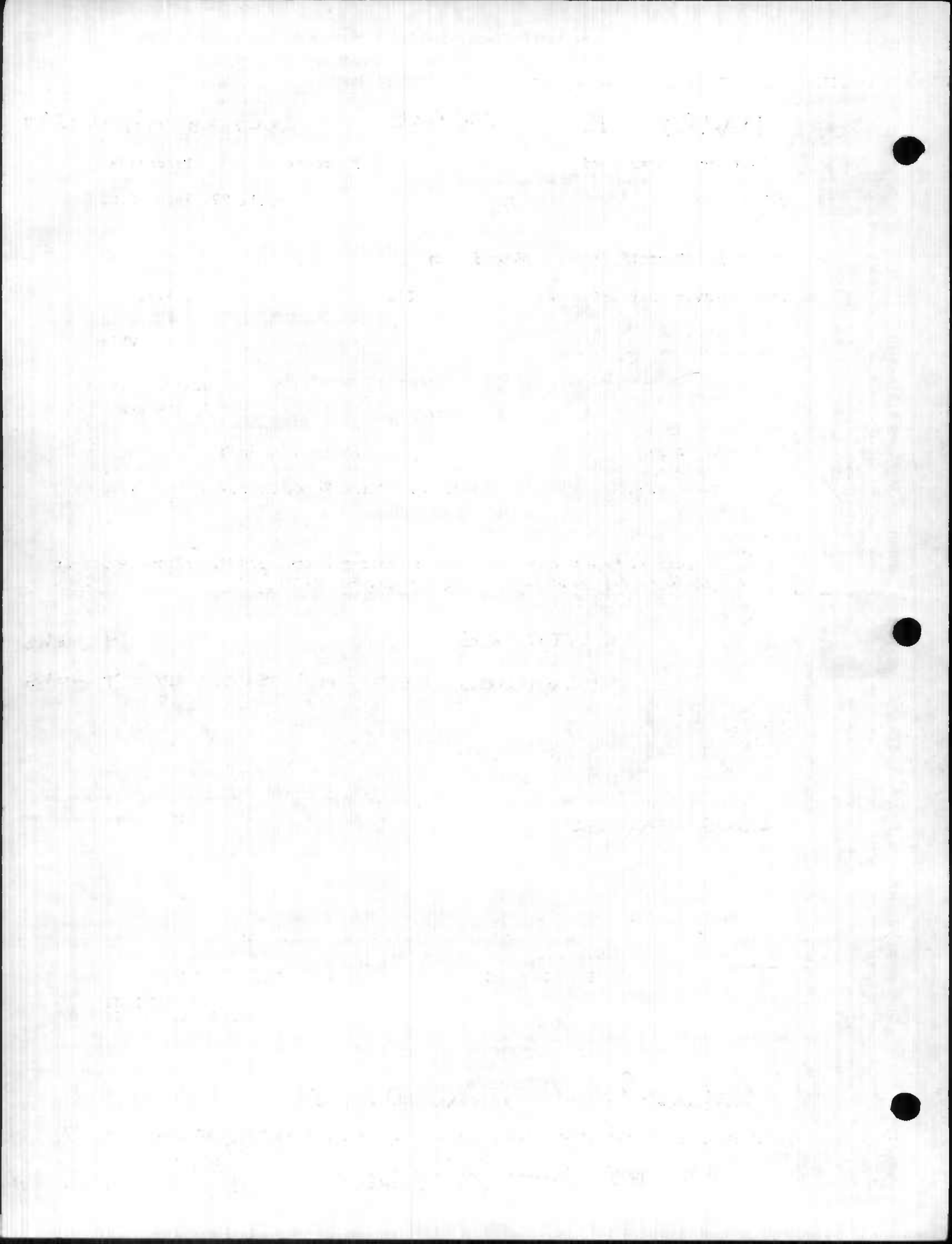
Certificate of Death

Reg. No. 99 26773

| | | | | | | | |
|---|---|---|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HARRY B MOORE | | | | 2. Date of Death Month JULY Day 28 Year 1999 | | 3. Time of Death 12:15AM |
| | 4a. Facility Name (If not institution, give street and number) 5041 Lynn Burke Road | | | | 4b. City, Town, or Location of Death Monrovia | | 4c. County of Death Frederick |
| Funeral Director | 5. Social Security Number 578-16-6631 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 79 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 29, 1920 | 9. Birthplace (State or Foreign Country) D.C. |
| | Usual Residence of Decedent | | | | | | |
| 10a. State MD | | 10b. County Carroll | | 10c. City, Town or Location Westminster | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 404 Baldwin Park Drive #A4 | | | | 10f. Zip Code 21157 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager | | 16b. Kind of Business/Industry Residential Apartments | |
| 17. Father's Name (First, Middle, Last) Harry B. Moore | | | | 18. Mother's Name (First, Middle, Maiden Surname) Kathryn L. Roth | | | |
| 19a. Informant's Name/Relationship (Type, Print) Julia Moore/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5041 Lynn Burke Road, Monrovia, MD 21770 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) STROKE | | | | | | | 4 weeks |
| Due to (or as a consequence of): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last FRACTURED LEFT HIP/SURGERY | | | | | | | 4 weeks |
| Due to (or as a consequence of): | | | | | | | |
| Due to (or as a consequence of): | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LUNG CANCER | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) JUNE 30, 1999 | | 28b. Time of Injury 3:13 P M | | 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how Injury occurred FELL DOWN STAIRS | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) WESTMINSTER 404 BALDWIN PL. DR. #194 MD | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier ARTHUR L. RUDOLPH, ATTENDING PHYSICIAN | | | |
| 29c. License number D21155 | | | | 29d. Date signed (Month, Day, Year) JULY 29, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ARTHUR L. RUDOLPH, MD 904 WASHINGTON RD WESTMINSTER, MARYLAND 21157 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 25 1999 | | | | 32. Registrar's Signature Geneva B. Sparks | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26774

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

John Joseph Mirowski

2. Date of Death

August 22, 1999 9:30 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

579 Brightview Drive

4b. City, Town, or Location of Death

Millersville

4c. County of Death

Anne Arundel

5. Social Security Number

220.58.1870

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 10, 1953

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

AA CO

10c. City, Town or Location

Millersville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

579 Brightview Drive

10f. Zip Code

21108

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: VIETNAM ERA

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

NamCo Pool

17. Father's Name (First, Middle, Last)

Thaddeus Mirowski

18. Mother's Name (First, Middle, Maiden Surname)

Sophie Switala

19a. Informant's Name/Relationship (Type, Print)

Sophie Switala mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8331 West Side Drive, millersville md 21108

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc

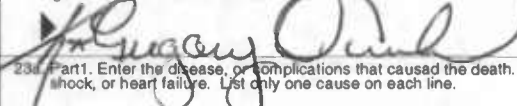
Date

8.23.99

20c. Location - City or Town, State

Baltimore, md

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Pink Funeral Home Pa
426 Crain Hwy SW Glen Burnie md 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

coronary artery disease

Due to (or as a consequence of):

b.

hypertension

Due to (or as a consequence of):

c.

emphysema

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

unknown

years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eugene D. Smith MD

29c. License number

D28640

29d. Date signed (Month, Day, Year)

August 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2414 Hightee Ct. Crofton MD 21114

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

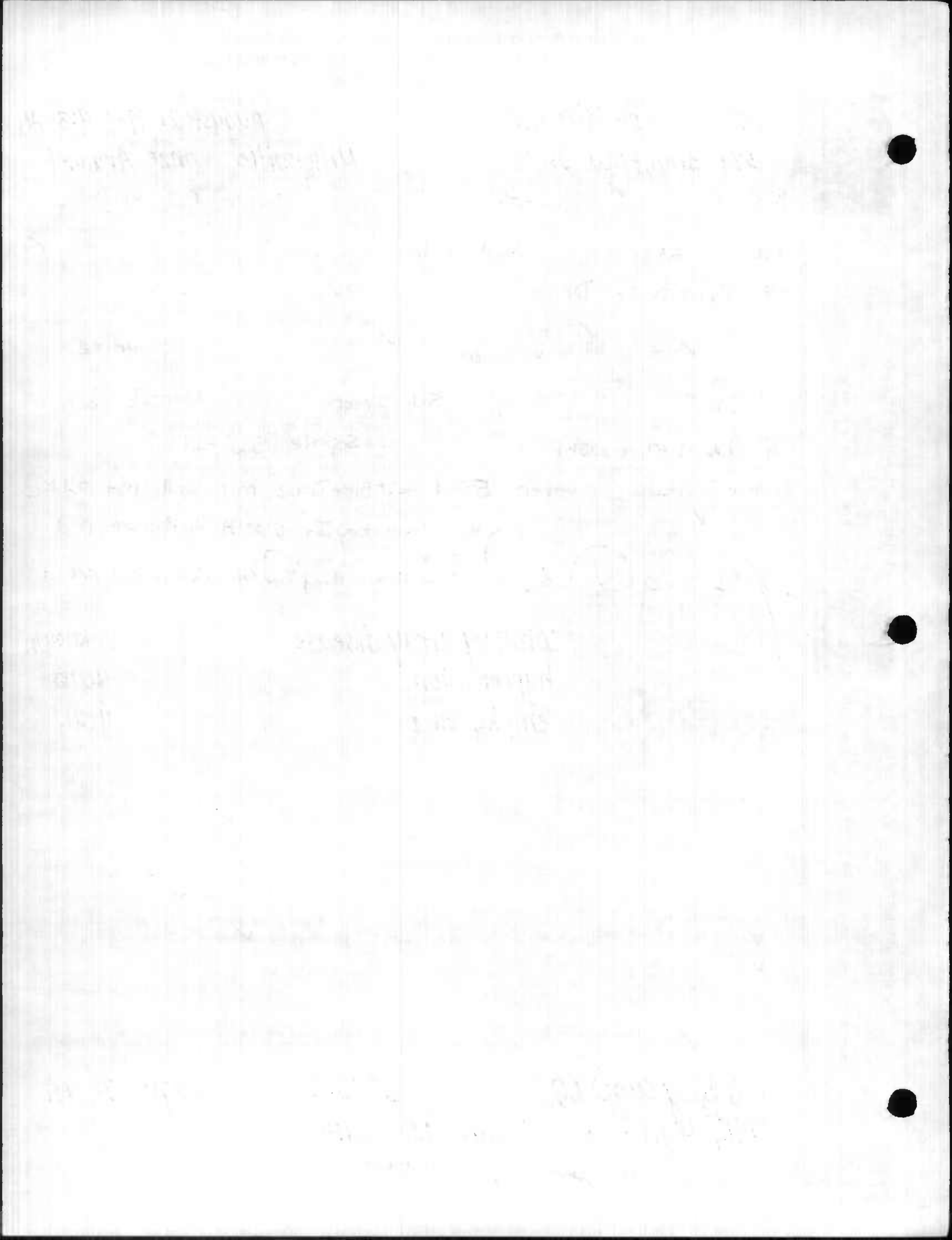
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26775

| | | | | | | | | | |
|---|--|--|---|--------------------------------|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Joseph Ellis Mahon, Jr.</u> | | | | 2. Date of Death Month Day Year <u>AUG. 21, 1999</u> | | 3. Time of Death <u>12:10 PM</u> | | |
| | 4a. Facility Name (If not institution, give street and number) <u>Homestyle Inn 6401 Route #40 West</u> | | | | 4b. City, Town, or Location of Death <u>CATONSVILLE</u> | | 4c. County of Death <u>BALTIMORE</u> | | |
| Funeral Director | 5. Social Security Number <u>213-92-3812</u> | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>35</u> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <u>09/11/1963</u> | | 9. Birthplace (State or Foreign Country) <u>Maryland</u> | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State <u>MD</u> | 10b. County <u>Baltimore</u> | 10c. City, Town or Location <u>Catonville</u> | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number <u>6120 Burnt Oak Road</u> | | | 10f. Zip Code <u>21228</u> | | 10g. Citizen of What Country? <u>United States</u> | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Jeweler</u> | | 16b. Kind of Business/Industry <u>Smyth</u> | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) <u>Joseph Ellis Mahon, Sr.</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Regina Marie Bruns</u> | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <u>Karen Mahon / wife</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6120 Burnt Oak Rd. Catonsville, MD 21228</u> | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Meadowridge Memorial</u> | | 20c. Location - City or Town, State <u>8/26/99 Dorsey, Maryland</u> | | | | |
| | 21. Signature of Funeral Service Licensee <u>Sean A. Imbrie</u> | | 22. Name and Address of Facility <u>Ambrose Funeral Home, Inc. 1388 Sulphur Spring Rd. Annapolis MD 21427</u> | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Intra-Oral Shotgun Wound</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| | 24a. Was an autopsy performed? <u>partial</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <u>AT SCENE</u> | | | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month/Day/Year) <u>Found 8-21-99</u> | | 28b. Time of Injury <u>Found 11:30</u> M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred <u>self inflicted shotgun wound</u> |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u>Building (Homestyle Inn)</u> | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <u>Baltimore Co., Md</u> | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier <u>Dennis J. Chute</u> | | | | 29c. License number <u>O.C.M.E</u> | | 29d. Date signed (Month, Day, Year) <u>AUG. 22, 1999</u> | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Dennis J. Chute</u> <u>111 Penn Street, Baltimore, Maryland 21201</u> | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) <u>AUG 26 1999</u> | | | | 32. Registrar's Signature <u>D. Sparks</u> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #26 PER MD G774 8-26-99 WR.

Certificate of Death

Reg. No. 99 26776

| | | | | | |
|---|---|---|---|--|--------------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Ethel Nole</u> | | 2. Date of Death Month Day Year <u>AUGUST 13 1999</u> | | 3. Time of Death <u>5:30 p.m.</u> |
| | 4a. Facility Name (If not institution, give street and number) <u>THE JOHNS HOPKINS HOSPITAL</u> | | 4b. City, Town, or Location of Death <u>BALTIMORE CITY</u> | | 4c. County of Death <u>n/a</u> |
| Funeral Director | 5. Social Security Number <u>230-58-1779</u> | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>52</u> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) <u>Oct. 27, 1946</u> | | 9. Birthplace (State or Foreign Country) <u>Va.</u> | | |
| Usual Residence of Decedent | | | | | |
| 10a. State <u>Md.</u> | | 10b. County <u>Baltimore</u> | | 10c. City, Town or Location <u>Woodlawn</u> | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number <u>6813 Townbrook Drive Apt. C</u> | | 10f. Zip Code <u>21207</u> | | 10g. Citizen of What Country? <u>USA</u> | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: <u>Black</u> | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th Grade</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business/Industry <u>Nations Bank</u> | |
| 17. Father's Name (First, Middle, Last) <u>Robert Pearson</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Ethel Easter</u> | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Jamica Nole-Cosby</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6813 Townbrook Drive Apt. C Baltimore, Md. 21207</u> | | | |
| 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Pearsontown Family Lot</u> | | 20c. Location - City or Town, State <u>Aug. 19 Brunswick Co., Va</u> | |
| 21. Signature of Funeral Service Licensee <u>H. E. Nutter</u> | | 22. Name and Address of Facility <u>Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216</u> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Subarachnoid hemorrhage</u> Due to (or as a consequence of): <u>b. Brain herniation</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death <u>3 hours</u> <u>3 hours</u> | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <u>M</u> | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <u>Jeffrey M. Richman M.D.</u> | | 29c. License number <u>RES-000</u> | | 29d. Date signed (Month, Day, Year) <u>AUG 13, 1999</u> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Jeffrey M. Richman M.D. 600 North Wolfe Street</u> | | | | | |
| 31. Date filed (Month, Day, Year) <u>AUG 26 1999</u> | | 32. Registrar's Signature <u>[Signature]</u> | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26777

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leah L. Nevius

2. Date of Death

August 24, 1999

3. Time of Death

5:10 PM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

214-22-0632

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 16, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11 Deer Pass Court

10f. Zip Code

21030

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

10th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assembler

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Norman Lutz

18. Mother's Name (First, Middle, Maiden Surname)

Ruby Osburn

19a. Informant's Name/Relationship (Type, Print) (Grand-son)

Patrick P. Platt, III

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 Deer Pass Court, Cockeysville, MD 21030

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cemetery 8/27/99 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Buen Ce Lueen

22. Name and Address of Facility

Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Chronic Renal Failure

e. Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D43725

29d. Date signed (Month, Day, Year)

8/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD 201-109 Back River Neck Road MD 21221

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

[Signature]

State
RegistrarPhysician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26778

| | | | | | | | | | | | |
|---|---|---|--|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James Albert Nawrocki, Sr. | | | | 2. Date of Death Month Day Year August 23 1999 | | | | 3. Time of Death 11:40 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number) Mariner Health of Forest Hill | | | | 4b. City, Town, or Location of Death Forest Hill | | | | 4c. County of Death Harford | | |
| Funeral Director | 5. Social Security Number 216-01-7675 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) April 9, 1914 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Fallston | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 2405 Derby Drive | | | | 10f. Zip Code 21047 | | | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Proprietor | | | | 16b. Kind of Business/Industry Gasoline Service Station | | | |
| 17. Father's Name (First, Middle, Last) Stanislaus Nawrocki | | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen Dylinski | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Constance Silvestri (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2405 Derby Drive, Fallston, MD 21047 | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stanislaus Cem. | | Date 8/27/99 | | 20c. Location - City or Town, State Dundalk, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee Mark T. Zang | | | | 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD 21014 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ischemic cardiomyopathy</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death 36m | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 26a. Date of Injury (Month, Day, Year) | | 26b. Time of Injury M | | 26c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier David S. Dunn | | | | 29c. License number 032257 | | | | 29d. Date signed (Month, Day, Year) August 24, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David S. Dunn 615 West MacPhail | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | | | 32. Registrar's Signature Jennifer B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26779

| | | | | | | | | |
|--|--|--|---|-------------------------------|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Charity Queen</i> | | | | 2. Date of Death Month <i>8</i> Day <i>22</i> Year <i>99</i> | | 3. Time of Death <i>1:45 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medicine System Baltimore City</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore City</i> | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number <i>213 36 6042</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>58</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>7/9/41</i> | |
| | 10a. State <i>MD</i> | | 10b. County <i>N/A</i> | | 10c. City, Town or Location <i>BALTIMORE</i> | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| Usual Residence of Decedent | | | | | | | | |
| 10e. Street and Number <i>1300 PENNSYLVANIA AVE. (APT 6)</i> | | | | 10f. Zip Code <i>21217</i> | | 10g. Citizen of What Country? <i>USA</i> | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>AFRO AMERICAN</i> | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i> | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HOUSEMAKER</i> | | | 16b. Kind of Business/Industry <i>HOME</i> | | |
| 17. Father's Name (First, Middle, Last) <i>WILLIAM S. MOORE SR.</i> | | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>IRENE G. MOORE</i> | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>SHANNON QUEEN</i> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4108 BELVIEU AVE. BALTO. MD. 21215 (3rd floor)</i> | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>KING, S PARK</i> | | 20c. Location - City or Town, State <i>RANDALLSTOWN, MD.</i> | | 20d. Date <i>8/28/99</i> | |
| 21. Signature of Funeral Service Licensee <i>Leulla Bay</i> | | | | | 22. Name and Address of Facility <i>ESTEP BROTHERS FUNERALHOME P. A. 1300 EUTAW PL BALTO. MD. 21217</i> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Sepsis</i> Due to (or as a consequence of): b. <i>Metastatic Breast Cancer</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute Renal Failure</i> <i>Hypertension</i> <i>Congestive Heart Failure</i> | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Stephen T. Woods MD</i> | | | | | 29c. License number <i>P13419</i> | | 29d. Date signed (Month, Day, Year) <i>8/22/99</i> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Stephen T. Woods, MD 22 S. Greene St. Baltimore, MD 21201</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>AUG 26 1999</i> | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26780

Certificate of Death

AMEND ITEMS: #8, 7, 10F PER F.H. G775 9-3-99 WR.

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last) Ranchhodlal A. Patel | | | | 2. Date of Death Month Day Year AUG 24, 1999 | | 3. Time of Death 10:49am | |
| 4a. Facility Name (If not institution, give street and number) 4305 Jefferson Avenue | | | | 4b. City, Town, or Location of Death Sykesville | | 4c. County of Death Carroll | |
| 5. Social Security Number 385-40-0350 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 66 65 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) DEC 14, 1932 | 9. Birthplace (State or Foreign Country) India |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Carroll | | 10c. City, Town or Location Sykesville | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 4305 Jefferson Avenue | | | | 10f. Zip Code 21228 21784 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Asian Indian | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chemist | | 16b. Kind of Business/Industry Textile Dye | |
| 17. Father's Name (First, Middle, Last) Ambalal Patel | | | | 16. Mother's Name (First, Middle, Maiden Surname) Dahigauri Patel | | | |
| 19a. Informant's Name/Relationship (Type, Print) Samir R. Patel/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 297 Donerail Ave. Powell, Ohio 43065 | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | Date 08/25/99 | | 20c. Location - City or Town, State Baltimore, MD | |
| 21. Signature of Funeral Service Licensee Dawn F. McDonald | | | | 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute myocardial Infarction hony. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Remote MI, CHF, Diabetes | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier D. Kalaria | | | | 29c. License number D 23015 | | 29d. Date signed (Month, Day, Year) 8/24/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINESH S. KALARIA 217 Washington Hts. Westminster, MD 21157 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | | | 32. Registrar's Signature G. Sparks | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

99-4956-025

cm

Unknown 99-186

Don Pozon

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26781

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|--------------------------------|---|---|
| 1. Decedent's Name (First, Middle, Last) Donato L. Pozon, Jr. | | 2. Date of Death Month Day Year August 21, 1999 | | 3. Time of Death 12:20 P.M. | |
| 4a. Facility Name (If not institution, give street and number) Rocks State Park, King & Queen's Seat | | 4b. City, Town, or Location of Death Jarrettsville | | 4c. County of Death Harford | |
| 5. Social Security Number 364-88-7754 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 32 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 30, 1966 |
| 9. Birthplace (State or Foreign Country) Philippines | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Perry Hall | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 4410 Cole Farm Road | | 10f. Zip Code 21236 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: Asian | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) electrical engineer | | 16b. Kind of Business/Industry government | |
| 17. Father's Name (First, Middle, Last) Donato L. Pozon, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname) Lorencita | | | |
| 19a. Informant's Name/Relationship (Type, Print) Alona Pamukcu - sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1325 Oklahoma Waterford, Michigan 48327 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Auburn Crematory | | 20c. Location - City or Town, State 8/27/99 Royal Oak, Michigan | |
| 21. Signature of Funeral Service Licensee Ann Y. Zink | | 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, Maryland 21229 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Injuries a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 08-21-1999 | | 28b. Time of Injury 11:50 A^M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject fell while rock climbing | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) State Park | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Jarrettsville, Maryland | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Magister One Shell Inc | | 29c. License number O.C.M.E. | |
| 29d. Date signed (Month, Day, Year) August 22, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margarita Korell M.D. | | 111 Penn Street, Baltimore, Maryland 21201 | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | 32. Registrar's Signature B. Sparks | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26782

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Julia Packard

2. Date of Death

Month Day Year
AUGUST 23, 1999

3. Time of Death

2:17 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

213-14-5848

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 14, 1922

9. Birthplace (State or Foreign Country)

Mass.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

39 Cedar Hill Rd.

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
316a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Home maker

16b. Kind of Business/Industry

Own home

17. Father's Name (First, Middle, Last)

Peter J. Finnegan

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Tierney

19a. Informant's Name/Relationship (Type, Print)

Mary Packard/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18808 Fox Chase Ct. Parkton, Md. 21120

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arlington National Cem.

Date

8/31/99

20c. Location - City or Town, State

Arlington, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 2120423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Sepsis

Due to (or as a consequence of):

b.

intraabdominal catastrophe

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

24 hrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Adenocarcinoma of gall bladder
with liver metastasis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Alexa Faraday MD

29c. License number

D43937

29d. Date signed (Month, Day, Year)

8/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alexa Faraday MD 6569 N Charles St, Baltimore MD

31. Date filed (Month, Day, Year)

Aug 26 1999

32. Registrar's Signature

21204

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
This certificate has been signed by the attending physician and
the Funeral Director. After this certificate has been signed by the attending physician and
the Funeral Director, page 2 should be detached for use as the burial-transit
completely filled in by the funeral director.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26783

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Rice

2. Date of Death

August 21 1999 4:06pm

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

248-34-6562

6. Sex

M F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 5, 1926

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10e. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

4017 Liberty Heights Avenue

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer-Construction

16b. Kind of Business/Industry

Unknown

17. Father's Name (First, Middle, Last)

Robert Rice

18. Mother's Name (First, Middle, Maiden Surname)

Annie Foster

19a. Informant's Name/Relationship (Type, Print)

Laura Cornish

sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 Vernon Hill Court Baltimore, Md. 21228

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forrest Veterans Aug. 26 Owings Mills, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert E. Nutter

22. Name and Address of Facility

Nutter Funeral Homes, Inc.

2501 Gwynns Falls PKWY Baltimore, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Physician

2 Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Roy Hannaki, M.D.

29c. License number

AS 2402321-RH2A36

29d. Date signed (Month, Day, Year)

August 21, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Roy Hannaki Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

AUG 25 1999

32. Registrar's Signature

Diana B. Sparks

State
Registrar

Patient Known As Robert Rice
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26784

| | | | | | | | | |
|---|--|--------------------------|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GEORGE J ROSE | | | | 2. Date of Death Month August Day 23 Year 1999 | | 3. Time of Death 5:11 AM | |
| | 4a. Facility Name (If not institution, give street and number) Veterans Hospital in Baltimore Maryland | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 223-32-7145 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 11 17 27 | 9. Birthplace (State or Foreign Country) V.A. |
| | Usual Residence of Decedent | | | | | | | |
| 10e. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 3409 Washington Ave | | | | 10f. Zip Code 21244 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (1-4 or 5+) na | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Packer | | 16b. Kind of Business/Industry Goetzes Meat Packing | | |
| 17. Father's Name (First, Middle, Last) Tolbert Rose | | | | 18. Mother's Name (First, Middle, Maiden Surname) Callie Jones | | | | |
| 19e. Informant's Name/Relationship (Type, Print) James Rose-Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3409 Washington Ave, Baltimore Md 21244 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Crownsville VA Cem. | | Date 8/27/99 | | 20c. Location - City or Town, State Crownsville, Md | |
| 21. Signature of Funeral Service Licensee Bladys Wanner | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. PNEUMONIA Due to (or as a consequence of): b. ESOPHAGEAL CANCER Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier Robert B. B. M.D. | | | 29c. License number P11736 | | 29d. Date signed (Month, Day, Year) August, 23, 1999 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT BOBER, 10 NORTH GREENE STREET, BALTIMORE, MD 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 28 1999 | | | 32. Registrar's Signature John B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF CHEMISTRY

RECEIVED
JAN 10 1964

FROM
J. H. DUNN

TO
J. H. DUNN

SUBJECT
RESEARCH REPORT

RESEARCH REPORT

RESEARCH REPORT

RESEARCH REPORT

RESEARCH REPORT

RESEARCH REPORT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26785

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JULIAN O. SALIK

2. Date of Death
Month Day Year

August 25 1999

3. Time of Death

20:45

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

Funeral
Director

5. Social Security Number

218-30-5764

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

SEP 17, 1909

9. Birthplace (State or Foreign Country)

Czechoslovakia

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4000 N. Charles Street, Apt. 1502

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Radiologist

16b. Kind of Business/Industry

Radiology

17. Father's Name (First, Middle, Last)

Max Salik

18. Mother's Name (First, Middle, Maiden Surname)

Regina Langer

19a. Informant's Name/Relationship (Type, Print)

Felicia Salik/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4000 N. Charles Street, Apt. 1502 Baltimore, MD 21218

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 8/26/99 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Edward A. Grigorchik

22. Name and Address of Facility

Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTICEMIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 WEEKS

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

CONGESTIVE HEART FAILURE 2°

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

R. P. P. MD

29c. License number

P12557

29d. Date signed (Month, Day, Year)

AUGUST 25, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RAPHAEL DODD, 5601 LOCHRAVEN BLVD. BALTIMORE MD 21239

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26786

Amended Item #8 per FH 6774 8/26/99 FW

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **DE LORES SHAREEE** 2. Date of Death Month **8** Day **19** Year **99** 3. Time of Death **4:25pm**

Funeral
Director

4a. Facility Name (If not Institution, give street and number) **CHURCH HOSPITAL** 4b. City, Town, or Location of Death **Baltimore** 4c. County of Death

5. Social Security Number **0660345091** 6. Sex ☐ M ☒ F **F** 7. Age (In yrs. last birthday) **54** Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth **8-7-44** (Month, Day, Year) 9. Birthplace (State or Foreign Country) **MD**

Usual Residence of Decedent 10a. State **MD** 10b. County **Baltimore** 10c. City, Town or Location **Baltimore** 10d. Inside City Limits ☐ No ☒ Yes

10e. Street and Number **3810 Ridgcroft Rd** 10f. Zip Code **21206** 10g. Citizen of What Country? **USA**

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **AFRICAN AMERICAN**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **11th** College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Homemaker** 16b. Kind of Business/Industry **Domestic**

17. Father's Name (First, Middle, Last) **Frank Powell** 18. Mother's Name (First, Middle, Maiden Surname) **Iola Mae Banks**

19a. Informant's Name/Relationship (Type, Print) **Angel Banks - Daughter** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **3810 Ridgcroft Rd. Baltimore, Md. 21206**

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Metro Crematory** Date **8-24-99** 20c. Location - City or Town, State **Balto. Md.**

21. Signature of Funeral Service Licensee **Jeff Miller** 22. Name and Address of Facility **Jeff Miller P.C. Funeral Home & Services 1639 N. Broadway Balto. Md. 21213**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **lung cancer w/ metastasis to pleura**

23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **End Stage Renal Disease** **Hypertension**

23c. Did tobacco use contribute to the cause of death? ☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier **Jeff Miller** 29c. License number **00053471** 29d. Date signed (Month, Day, Year) **8/19/99**

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) **Amittan, MD 98 N. BROADWAY ST 410 21231**

31. Date filed (Month, Day, Year) **AUG 26 1999** 32. Registrar's Signature **B. Sparks**

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26787

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

June

Scovens

2. Date of Death
Month Day Year

August 21, 1999

3. Time of Death

15:14

4a. Facility Name (If not institution, give street and number)

THE Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore, City

4c. County of Death

Funeral
Director

5. Social Security Number

218-60-5421

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

8 5 52

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1419 North Chester St.

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

James Turner

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Benson

19a. Informant's Name/Relationship (Type, Print)

Joyce Murdock-Cousins

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4620 Chafford Ave. Balto., Md. 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Vashell Cemetery

Date

8-27-99 Baltimore, Maryland

21. Signature of Funeral Service Licensee

Jeff Miller

22. Name and Address of Facility

Jeff Miller P.C. Funeral Home & Services
1639 N. Broadway Balto., Md. 2121323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Hypotension

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

6 hours

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Right Ventricular Failure

Due to (or as a consequence of):

2 days

c. Pulmonary Hypertension

Due to (or as a consequence of):

5 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

K. Keel Bruce MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

August 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Keith Bruce 600 N. Wolfe Street, Tower 110, Baltimore MD 21287

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26788

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|---|--|--|--|--|--|---|---|---------------|--|----|-------------|-------|----|--------------------|------|----|---------------------|-------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Wilhelmina Simons | | | | 2. Date of Death Month Day Year August 21, 1999 | | 3. Time of Death 12:25pm | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Mariner Health of Catonsville | | | | 4b. City, Town, or Location of Death Catonsville | | 4c. County of Death Baltimore | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 219-20-8057 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 94 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 1, 1904 | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Howard | | 10c. City, Town or Location Baltimore | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 6636 Washington Blvd. TRLR #106 | | 10f. Zip Code 21227 | | 10g. Citizen of What Country? United States | | | | | | | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Carl Lanehart | | | | 18. Mother's Name (First, Middle, Maiden Surname) Unknown | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Annette Simons/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6636 Washington Blvd. TRLR #106 Baltimore, MD 21227 | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | 20c. Location - City or Town, State Baltimore, Maryland | | 20d. Date 8/25/99 | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee Guanta R Thomas | | | | 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229 | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>renal failure</td> <td>Approximate interval between Onset and Death 1 wk</td> </tr> <tr> <td>b.</td> <td>dehydration</td> <td>2 wks</td> </tr> <tr> <td>c.</td> <td>end stage Dementia</td> <td>5 yr</td> </tr> <tr> <td>d.</td> <td>Alzheimer's disease</td> <td>10 yr</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | renal failure | Approximate interval between Onset and Death 1 wk | b. | dehydration | 2 wks | c. | end stage Dementia | 5 yr | d. | Alzheimer's disease | 10 yr |
| | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | renal failure | Approximate interval between Onset and Death 1 wk | | | | | | | | | | | | | | | | | |
| b. | | dehydration | 2 wks | | | | | | | | | | | | | | | | | | |
| c. | | end stage Dementia | 5 yr | | | | | | | | | | | | | | | | | | |
| d. | | Alzheimer's disease | 10 yr | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td colspan="2">23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> <td colspan="2">24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> </table> | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Marcelino D. Alvarez | | 29c. License number D29769 | | 29d. Date signed (Month, Day, Year) 8/23/99 | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marcelino D. Alvarez 1120 N. Rolling Rd. Baltimore, Md. | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | 32. Registrar's Signature Geneva S. Sparks | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26789

| | | | | | | | | |
|---|---|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ellen E. Schroeder | | | | 2. Date of Death Month 8 Day 24 Year 99 | | 3. Time of Death 8:50 pm | |
| | 4a. Facility Name (If not Institution, give street and number) Joseph Richey Hospice | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 217-09-9165 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 19 1917 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10. Usual Residence of Decedent 10a. State Maryland | | 10b. City, Town or Location Baltimore | | 10c. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10d. Street and Number 2053 Whistler Avenue | | 10e. Zip Code 21230 | | 10f. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk | | 16b. Kind of Business/Industry Pharmacy | | | | |
| 17. Father's Name (First, Middle, Last) Lyman Cato Howe | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen McHugh | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Eileen M. Tynan | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5811 Oakland Rd. Arbutus, Maryland 21227 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery | | 20c. Date 8-27-1999 | | 20d. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Maryland 21229 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Congestive Heart Failure Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death Years Years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Hospice | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Julia A. Haller | | 29c. License number D32600 | | 29d. Date signed (Month, Day, Year) 8/25/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Haller, 600 N. Wolfe St Balto. 21287 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Ellen Schroeder
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner
Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26790

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERTA BEDFORD SALOMON

2. Date of Death

August 21 1999 1207PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

222-20-1246

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

1-27-17

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

MD

10b. County

CAROLINE

10c. City, Town or Location

DENTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

114 South First Street

10f. Zip Code

21629

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

JOHN CLAUDE BEDFORD

18. Mother's Name (First, Middle, Maiden Summa)

ALICE HUEY

19a. Informant's Name/Relationship (Type, Print)

William J. Robinson III, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7635 TRED AVON CIRCLE, EASTON, MD. 21601

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

DIRECTOR
[Signature]

22. Name and Address of Facility

STATE ANATOMY BLDG. BALT., MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. pulmonary embolism
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

5 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident 6 ☐ Could not be
3 ☐ Suicide 6 ☐ determined
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Matthew J. Fischer MD

29c. License number

D52251

29d. Date signed (Month, Day, Year)

08/22/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew J. Fischer, Memorial Hospital

State
Registrar

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

[Signature]

Roberta Salomon

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text at the top of the page, possibly a title or header.

Handwritten text in the upper left section.

Handwritten text in the upper right section.

Handwritten text in the middle left section.

Handwritten text in the middle right section.

Handwritten text in the lower left section.

Handwritten text in the lower middle section.

Handwritten text in the bottom left section.

Handwritten text in the bottom right section.

99-4930-510

jhm

UNK. 99-185

Jeanette Sabb AMEND ITEMS: #23 PART I, 27, 28A-F

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

PER MEO 6774-8-27-99 JPR

Certificate of Death

Reg. No.

99 26791

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jeanette Sabb

2. Date of Death

Month Day Year
AUGUST 20, 1999

3. Time of Death

21:56 PM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-76-7037

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

35

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
August 21, 1963

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4406 Norfolk Ave.

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Food Service Worker

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Jimmy Sabb

18. Mother's Name (First, Middle, Maiden Surname)

Patricia Carlton

19a. Intomment's Name/Relationship (Type, Print)

Mrs. Patricia Sabb (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4308 W. Forest Park Ave. Balto. Md. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion

Date

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE ETHANOL AND NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☒ Could not be determined

28a. Date of Injury (Month, Day Year)

FOUND: 8-20-99

28b. Time of Injury

FOUND: 9:00

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

FOUN IN HOUSE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4302- 1/2 NORFORK AVE. BALTIMORE, MARYLAND

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dennis J. Chute

29c. License number

OCME

29d. Date signed (Month, Day, Year)

AUGUST 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

Dennis J. Chute

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26792

| | | | | | | | | | |
|---|---|---|--|--|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Yoshio Sakaue | | | | 2. Date of Death Month Day Year August 10 1999 | | 3. Time of Death 21:50 | | |
| | 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 319-26-1789 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) April 25, 1918 | | |
| | 9. Birthplace (State or Foreign Country) California | | 10a. State Virginia | | 10b. County Arlington | | 10c. City, Town or Location n/a | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 1600 South Eads Street Apt. 1111 N | | 10f. Zip Code 22202 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Asian | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) director | | 16b. Kind of Business/Industry civil service | | 17. Father's Name (First, Middle, Last) Sokuma Sakaue | | 18. Mother's Name (First, Middle, Maiden Surname) Naru Hori | |
| 19a. Informant's Name/Relationship (Type, Print) Miyoko Sakaue - wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 South Eads Street #1111 N, Arlington, Va 22202 | | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Everly Wheatley Crematory | | 20c. Location - City or Town, State Alexandria, Virginia | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Everly Colonial Funeral Home 6161 Leesburg Pike Falls Church, Virginia 22044 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Respiratory Failure Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Lymphoma Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death 3 days 2 days 3 years | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gastrointestinal Bleed | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) M | | 28b. Time of Injury 1 Yes <input type="checkbox"/> No | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D0053335 | | 29d. Date signed (Month, Day, Year) August 18, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Matsui, MD 600 N. Wolfe St. Baltimore, MD 21287 | | 31. Date filed (Month, Day, Year) AUG 26 1999 | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26793

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Gertrude E. Schultz | | | | 2. Date of Death Month Day Year Aug. 23, 1999 | | 3. Time of Death 6:20 AM | |
| | 4a. Facility Name (If not institution, give street and number) Stella Maris | | | | 4b. City, Town, or Location of Death Timonium | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 214-20-7548 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 90 Yrs. | 8. Date of Birth (Month, Day, Year) Jan. 5, 1909 | 9. Birthplace (State or Foreign Country) Maryland | | | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Baltimore | 10c. City, Town or Location Towson | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 1513 Dellsway Road | | 10f. Zip Code 21286 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 yrs. College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Wire Inspector | | 16b. Kind of Business/Industry Western Electric | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) James Joseph McGuire | | | | 18. Mother's Name (First, Middle, Maiden Surname) Jennie Lillian Gerlach | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mrs. M. Joan Popoli/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1513 Dellsway Road Towson, Maryland 21286 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer Cem. 8/25/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Probable Myocardial Infarction 2 hrs Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease mother Severe Dementia 5 yrs Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| State Registrar | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier | | | | 29c. License number D 30641 | | 29d. Date signed (Month, Day, Year) August 23 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramesh Sabapathi 201-109 Back River Neck Road Baltimore MD 21201. | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 26 1999 | | | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

99-4981-510

99-189

SHARON L. SUGDEN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26794

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Sharon L. Sugden | | | | 2. Date of Death Month Day Year AUGUST 23, 1999 | | 3. Time of Death 5:42P.M. | |
| 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| 5. Social Security Number 216-96-8005 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 35 Yrs. | | 8. Date of Birth (Month, Day, Year) May 28 1964 | |
| 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3302 Leverton Ave | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier | | 16b. Kind of Business/Industry Fast Food | | 17. Father's Name (First, Middle, Last) Robert J. Sugden Sr. | |
| 18. Mother's Name (First, Middle, Maiden Surname) Frances L. Gregory | | 19a. Informant's Name/Relationship (Type, Print) Richard E. Sugden /son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6419 Hartwait St. Baltimore, MD 21224 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | 20c. Date Aug 28 1999 | | 20d. Location - City or Town, State Baltimore, MD | | 21. Signature of Funeral Service Licensee Anthony C. Connelly | |
| 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 | | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple injuries Due to (or as a consequence of): | | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 23d. Immediate Cause (Final disease or condition resulting in death) | | 23e. Due to (or as a consequence of): | | 23f. Due to (or as a consequence of): | | 23g. Due to (or as a consequence of): | |
| 23h. Due to (or as a consequence of): | | 23i. Due to (or as a consequence of): | | 23j. Due to (or as a consequence of): | | 23k. Due to (or as a consequence of): | |
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| 23dv. Due to (or as a consequence of): | | 23cd. Due to (or as a consequence of): | | 23ce. Due to (or as a consequence of): | | 23cf. Due to (or as a consequence of): | |
| 23dv. Due to (or as a consequence of): | | 23cd. Due to (or as a consequence of): | | 23ce. Due to (or as a consequence of): | | 23cf. Due to (or as a consequence of): | |
| 23dv. Due to (or as a consequence of): | | 23cd. Due to (or as a consequence of): | | 23ce. Due to (or as a consequence of): | | 23cf. Due to (or as a consequence of): | |
| 23dv. Due to (or as a consequence of): | | 23cd. Due to (or as a consequence of): | | 23ce. Due to (or as a consequence of): | | 23cf. Due to (or as a consequence of): | |
| 23dv. Due to (or as a consequence of): | | 23cd. Due to (or as a consequence of): | | 23ce. Due to (or as a consequence of): | | 23cf. Due to (or as a consequence of): | |
| 23dv. Due to (or as a consequence of): | | 23cd. Due to (or as a consequence of): | | 23ce. Due to (or as a consequence of): | | 23cf. Due to (or as a consequence of): | |
| 23dv. Due to (or as a consequence of): | | 23cd. Due to (or as a consequence of): | | 23ce. Due to (or as a consequence of): | | 23cf. Due to (or as a consequence of): | |
| 23dv. Due to (or as a consequence of): | | 23cd. Due to (or as a consequence of): | | 23ce. Due to (or as a consequence of): | | 23cf. Due to (or as a consequence of): | |
| 23dv. Due to (or as a consequence of): | | 23cd. Due to (or as a consequence of): | | 23ce. Due to (or as a consequence of): | | 23cf. Due to (or as a consequence of): | |
| 23dv. Due to (or as a consequence of): | | 23cd. Due to (or as a consequence of): | | 23ce. Due to (or as a consequence of): | | 23cf. Due to (or as a consequence of): | |
| 23dv. Due to (or as a consequence of): | | 23cd. Due to (or as a consequence of): | | 23ce. Due to (or as a consequence of): | | 23cf. Due to (or as a consequence of): | |
| 23dv. Due to (or as a consequence of): | | 23cd. Due to (or as a consequence of): | | 23ce. Due to (or as a consequence of): | | 23cf | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26795

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert D. Suggs

2. Date of Death

Month

Day

Year

August 23, 1999

3. Time of Death

8:30 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

9256 Red Cart Ct.

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

527-82-1837

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 10, 1951

9. Birthplace (State or Foreign Country)

Arizona

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9256 Red Cart Ct.

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Jockey Agent

16b. Kind of Business/Industry

Horse Racing

17. Father's Name (First, Middle, Last)

Cecil V. Suggs

18. Mother's Name (First, Middle, Maiden Surname)

Rita Chisulm

19a. Informant's Name/Relationship (Type, Print)

Ms. Linda Ann Robinson Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9256 Red Cart Ct. Columbia, Maryland 21045

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory

Date

08/25/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Robert D. Suggs

22. Name and Address of Facility

Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 2104323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Adenocarcinoma of the Stomach

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

28 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Robert D. Suggs DIRECTOR, DIVISION
OF MEDICAL ONCOLOGY

29c. License number

D23675

29d. Date signed (Month, Day, Year)

8-23-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Donehower, Ross C., MD FACP 600 North Wolfe St. Baltimore, MD 21287-8936

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Robert D Suggs

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

A1410

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26796

| | | | | | | | | | | | |
|--|--|---|---|---|---|--|---|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Vivian Anna Torney | | | | | 2. Date of Death Month Day Year August 22, 1999 | | 3. Time of Death 8:00am | | | |
| | 4a. Facility Name (If not institution, give street and number) 1222 Pine Heights Avenue | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | | |
| Funeral Director | 5. Social Security Number 214-20-9885 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 10, 1914 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | 10a. State Maryland | | 10b. County n/a | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 10e. Street and Number 1222 Pine Heights Avenue | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | | | |
| | 17. Father's Name (First, Middle, Last) Michael J. Moran | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Loretta Grimes | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Richard E. Torney / Son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 174 Virginia Lane, Apt. L, Glen Burnie, Md. 21061 | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Mausoleum | | 20c. Date 8/27/99 | | 20d. Location - City or Town, State Baltimore, Maryland | | | | |
| | 21. Signature of Funeral Service Licensee | | | | | 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Twenty years Due to (or as a consequence of): b. ISCHEMIC CARDIOMYOPATHY TEN YEARS Due to (or as a consequence of): c. PAROXYSMAL ATRIAL FIBRILLATION FIVE YEARS Due to (or as a consequence of): d. ACUTE BRONCHITIS one month | | | | | Approximate Interval Between Onset and Death | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Jonathan Safren MD ATTENDING CARDIOLOGIST | | 29c. License number MARYLAND 00041711 | | 29d. Date signed (Month, Day, Year) August 23, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONATHAN SAFREN MD 3449 WILKENS AVENUE SUITE 300 BALTIMORE, MARYLAND 21229 | | | | | 31. Date filed (Month, Day, Year) Aug 26 1999 | | | | | | |
| 32. Registrar's Signature B. Sparks | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26797

| | | | | | | | | |
|--|---|---------------------------|---|--|--|---|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Charles Thomas</i> | | | | 2. Date of Death Month <i>8</i> Day <i>24</i> Year <i>1999</i> | | 3. Time of Death <i>7:38 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>SANDTOWN/WINCHESTER NURSING CENTER</i> | | | | 4b. City, Town, or Location of Death <i>BALTIMORE</i> | | 4c. County of Death <i>N/A</i> | |
| Funeral Director | 5. Social Security Number <i>220-74-2103</i> | | 6. Sex <i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>81</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>9-10-17</i> | 9. Birthplace (State or Foreign Country) <i>MD.</i> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State <i>MD.</i> | | 10b. County <i>N/A</i> | | 10c. City, Town or Location <i>BALTIMORE</i> | | | 10d. Inside City Limits <i>1</i> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number <i>201 WASHINGTON ST.</i> | | | | 10f. Zip Code <i>21231</i> | | 10g. Citizen of What Country? <i>USA</i> | | |
| 11. Marital Status <i>3</i> <input checked="" type="checkbox"/> Widowed <i>4</i> <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <i>1</i> <input checked="" type="checkbox"/> Yes <i>2</i> <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> <input type="checkbox"/> Yes <i>2</i> <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i> | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>-12-</i> College (1-4or 5+) <i>-0-</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>DISABLED</i> | | 16b. Kind of Business/Industry <i>N/A</i> | | |
| 17. Father's Name (First, Middle, Last) <i>CHARLES THOMAS</i> | | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>ANNIE GAINS</i> | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>HILDA THOMAS (SISTER)</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>201 WASHINGTON ST. BALTIMORE, MARYLAND 21231</i> | | | | |
| 20a. Method of Disposition <i>1</i> <input checked="" type="checkbox"/> Burial <i>2</i> <input type="checkbox"/> Cremation <i>3</i> <input type="checkbox"/> Removal from State <i>4</i> <input type="checkbox"/> Donation <i>5</i> <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>GARRISON FOREST VETERANS</i> | | Date <i>8-31-99</i> | | 20c. Location - City or Town, State <i>OWINGS MILLS, MARYLAND</i> | |
| 21. Signature of Funeral Service Licensee <i>Vernon R. Bailey</i> | | | | 22. Name and Address of Facility <i>VERNON BAILEY FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>a. Arrhythmia 2° to atherosclerotic</i> <i>b. Cardiovascular disease.</i> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <i>1</i> <input type="checkbox"/> Yes <i>2</i> <input checked="" type="checkbox"/> No <i>3</i> <input type="checkbox"/> Probably <i>4</i> <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <i>1</i> <input type="checkbox"/> Yes <i>2</i> <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <i>1</i> <input type="checkbox"/> Yes <i>2</i> <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <i>1</i> <input type="checkbox"/> Yes <i>2</i> <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <i>1</i> <input type="checkbox"/> Inpatient <i>2</i> <input type="checkbox"/> ER/Outpatient <i>3</i> <input type="checkbox"/> DOA Other: <i>4</i> <input checked="" type="checkbox"/> Nursing Home <i>5</i> <input type="checkbox"/> Residence <i>6</i> <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <i>1</i> <input checked="" type="checkbox"/> Natural <i>5</i> <input type="checkbox"/> Pending investigation <i>2</i> <input type="checkbox"/> Accident <i>6</i> <input type="checkbox"/> Could not be determined <i>3</i> <input type="checkbox"/> Suicide <i>4</i> <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <i>1</i> <input type="checkbox"/> Yes <i>2</i> <input checked="" type="checkbox"/> No | |
| | | | 28d. Describe how Injury occurred | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <i>1</i> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier <i>Agneta M.D.</i> | | | 29c. License number <i>D39127</i> | | 29d. Date signed (Month, Day, Year) <i>8/26/99</i> |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>A. AHMED 821 N. Eutaw street Baltimore MD 21201</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>AUG 26 1999</i> | | | 32. Registrar's Signature <i>P. Sparks</i> | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26798

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alfred Tasker

2. Date of Death

August 19, 1999 9:40 AM

3. Time of Death

9:40 AM

4a. Facility Name (If not institution, give street and number)

Millennium Health Rehab. Ctr. of Liberty Hgts.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

214-66-3626

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs, last birthday)

44 Yrs.

8. Date of Birth

Feb. 11, 1955

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County

N/A

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

9241 Harvest Rush Rd.

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

Never Worked

17. Father's Name (First, Middle, Last)

Clarence Tasker

18. Mother's Name (First, Middle, Maiden Surname)

Annie Snowden

19a. Informant's Name/Relationship (Type, Print, Social Worker)

Mrs. Margaret Henderson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4017 Liberty Hgts. Ave. Balto. Md. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion

20c. Location - City or Town, State

8/30/99 Lansdowne, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HUNTINGTON CHOREA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28i. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Ahmed MD

29c. License number

D39127

29d. Date signed (Month, Day, Year)

8/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. AHMED 821 N. EUTAW STREET BALTIMORE MD 21201

State
Registrar

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

A. Ahmed

Baltimore, Maryland 21215-0020

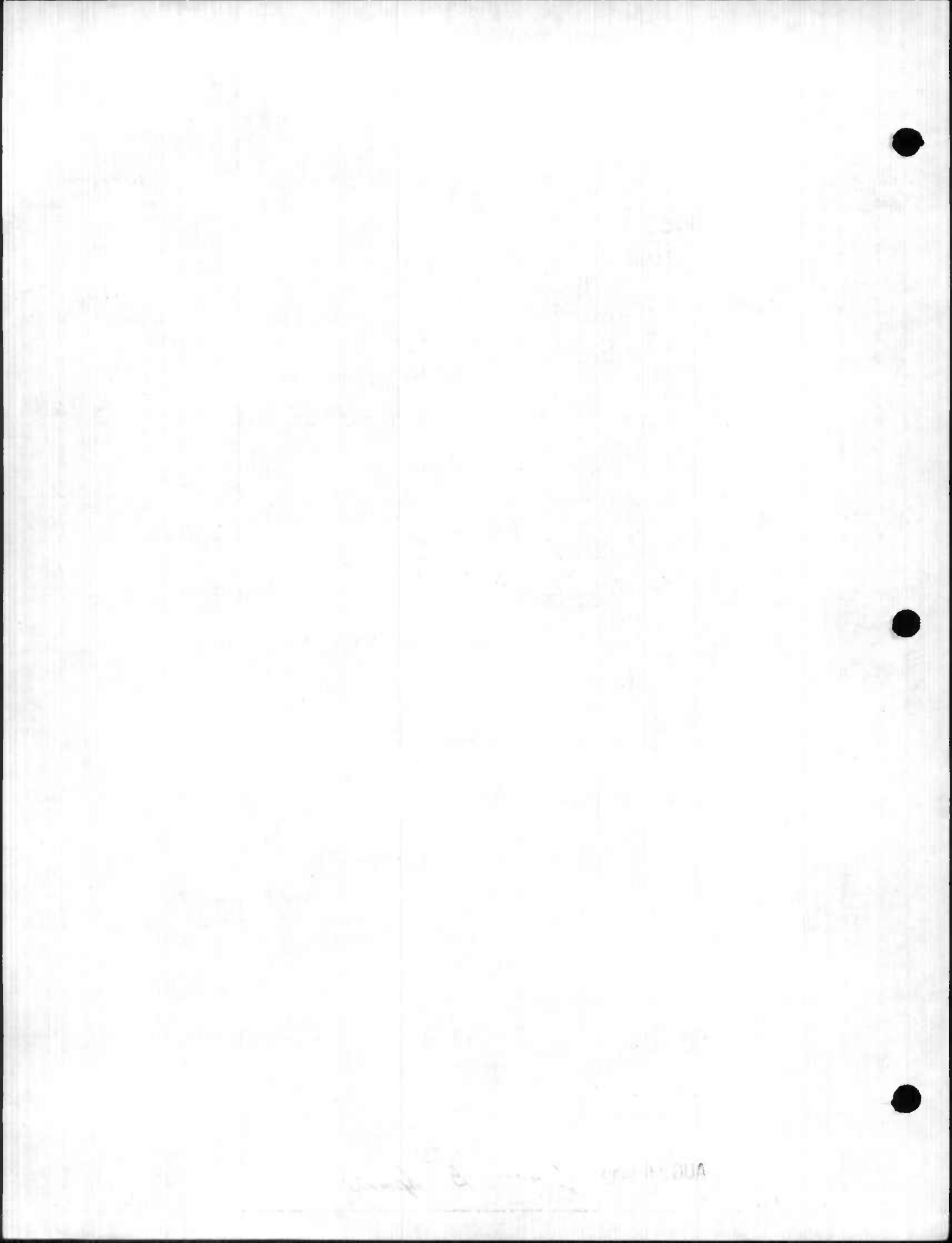
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26799

| | | | | | | | | |
|---|---|---|--|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOHNNIE MAE THOMAS | | | | 2. Date of Death Month 8 - Day 22 - Year 99 | | 3. Time of Death 1750 H | |
| | 4a. Facility Name (If not institution, give street and number) BON SECOURS Hospital | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 218-44-0490 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 53 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 03/11/1946 | 9. Birthplace (State or Foreign Country) Maryland |
| | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 3008 Edmondson Avenue | | 10f. Zip Code 21223 | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembly Line Worker | | 16b. Kind of Business/Industry Noxell Factory | | | | |
| 17. Father's Name (First, Middle, Last) John H. Brand | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ella Mae Sheppard | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Stacey Thomas / Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3008 Edmondson Ave., Baltimore, Maryland 21223 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery | | Date 08/27/99 | | 20c. Location - City or Town, State Landsdowne, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility The Derrick C. Jones Funeral Hm., 4611 Park Heights Ave., Baltimore, Maryland 21215 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Severe anemia Due to (or as a consequence of): b. gastrointestinal bleeding Due to (or as a consequence of): c. End stage renal disease Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D0016263 | | 29d. Date signed (Month, Day, Year) 8-24-99 | | |
| 30. Name and address of person who completed cause of death from 23a (Type, Print) JUAN A. BELTRAN 1940 W. BALT ST. BALT., MD 21223 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

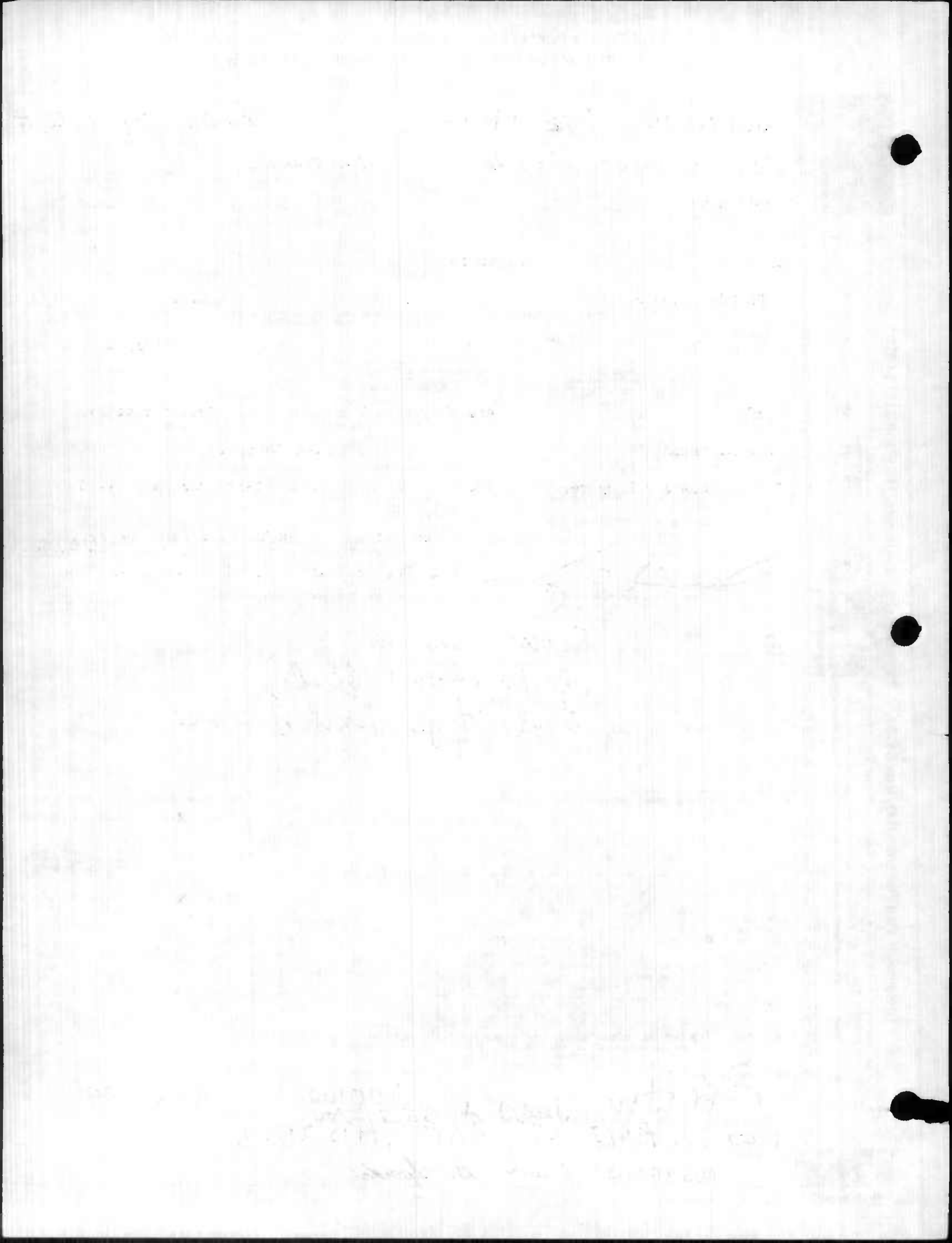
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



99-4826-005

UNK 99-183

asp

DONNELL WILLIAMS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26800

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Donnell Williams

2. Date of Death

Month
AUGUSTDay
17Year
1999

3. Time of Death

2350

4a. Facility Name (If not institution, give street and number)

1965 E. JOPPA RD.

4b. City, Town, or Location of Death

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

217-68-1680

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

28 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
4 3 71

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

904 Holgate Drive #1

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

B.F.I.

17. Father's Name (First, Middle, Last)

Mack Williams

18. Mother's Name (First, Middle, Maiden Surname)

Gloria Brown

19a. Informant's Name/Relationship (Type, Print)

Gloria Williams- Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3917 Dudley Ave. Baltimore, Maryland 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Voshell Cemetery

Date

8-26-99 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jeff Miller

22. Name and Address of Facility

Jeff Miller P.C. Funeral Home & Services
1639 N. Broadway Balto. Md. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head injury. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

MULTIPLE GUNSHOT WOUNDS OF HEAD SECONDS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☒ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

8/17/99

28b. Time of Injury

2345 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Found Shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1965 E. JOPPA RD.

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeff Miller

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

AUGUST 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SMIALEK

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

Benjamin B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26801

| | | | | | |
|---|--|--|--|---|------------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILLIAM WEISS | | 2. Date of Death Month Day Year AUGUST 24, 1999 | | 3. Time of Death 3:12 PM |
| | 4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 145-22-0012 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 88 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) MAR. 9, 1911 | | 9. Birthplace (State or Foreign Country) ND | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 304 KERNEWAY | | 10f. Zip Code 21212 | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: COAST GUARD | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PROPRIETOR | | 16b. Kind of Business/Industry REAL ESTATE | | 17. Father's Name (First, Middle, Last) MORRIS WEISS | |
| 18. Mother's Name (First, Middle, Maiden Surname) GUSSIE TEITLEBAUM | | 19a. Informant's Name/Relationship (Type, Print) RUTH WEISS / WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 KERNEWAY - BALTIMORE, MD 21212 | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHIZUK AMUNO ARLINGTON | | 20c. Location - City or Town, State 8/26/99 BALTIMORE, MD | |
| 21. Signature of Funeral Service Licensee <i>Jay Alan Lewis</i> | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): c. Chronic Renal Failure Due to (or as a consequence of): d. CARDIOMYOPATHY Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>James H. H.D.</i> | | 29c. License number 08297 | | 29d. Date signed (Month, Day, Year) 8/25/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #8 PER FH G774 8/26/99 AH

Certificate of Death

Reg. No.

99 26802

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary Rita Wiswell | | | | 2. Date of Death Month Day Year August 22, 1999 | | 3. Time of Death 6:00am | |
| | 4a. Facility Name (If not institution, give street and number) St. Martin's Home | | | | 4b. City, Town, or Location of Death Catonsville | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 471-14-2656 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 28, 1919 | |
| | 9. Birthplace (State or Foreign Country) Minnesota | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Catonsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 601 Maiden Choice Lane | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Receptionist | | 16b. Kind of Business/Industry Nursing Home | | | |
| | 17. Father's Name (First, Middle, Last) Albert Appert | | | | 18. Mother's Name (First, Middle, Maiden Surname) Celestine Hoffman | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Donald Appert Wiswell/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13712 Shannon Avenue Laurel, Maryland 20707 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Assumption Cemetery | | 20c. Location - City or Town, State 8/26/99 St. Cloud, Minnesota | | | |
| | 21. Signature of Funeral Service Licensee <i>Juanita R. Thomas</i> | | | | 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 3 WEEKS | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RECURRENT STROKES HYPERTENSIVE CARDIOVASCULAR DISEASE HYPOTHYROIDISM, CHRONIC ATRIAL FIB. | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Kamalee Dango</i> | | | | 29c. License number D18368 | | 29d. Date signed (Month, Day, Year) 8-23-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOMAL K. DANGO M.D. 3455 WILKENS AVE, Suite 308. BALTO. MD 21229 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | 32. Registrar's Signature <i>G. Sparks</i> | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26803

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) George Milton Walton | | 2. Date of Death Month August Day 25 Year 1999 | | 3. Time of Death 4:55 AM | |
| 4a. Facility Name (If not institution, give street and number) Maryland General Hospital | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death | |
| 5. Social Security Number 223-52-8071 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 59 Yrs. | |
| 8. Date of Birth (Month, Day, Year) 1-6-1940 | | 9. Birthplace (State or Foreign Country) Va | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 1811 Light Street | | 10f. Zip Code 21230 | | 10g. Citizen of What Country? U.S.A | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (14 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sofa Maker | | 16b. Kind of Business/Industry Sheraton Manufacture | |
| 17. Father's Name (First, Middle, Last) Robert Walton | | 18. Mother's Name (First, Middle, Maiden Surname) Gladys Longhorn | | | |
| 19a. Informant's Name/Relationship (Type, Print) Rose M. Taylor - Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 Yellowwood Avenue Baltimore, MD 21209 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) FAMILY PLOT | | 20c. Location - City or Town, State 8-29-99 Keysville, Va | |
| 21. Signature of Funeral Service Licensee Blondy Wane | | 22. Name and Address of Facility March F. H. West 4300 Wabash Avenue Balto, MD 21215 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Diabetic Ketoacidosis & Marked Dehydration Due to (or as a consequence of): Diabetes Due to (or as a consequence of): Cerebrovascular Accident Due to (or as a consequence of): Sepsis. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Amatun U. Naem MD | | 29c. License number D15503 | | 29d. Date signed (Month, Day, Year) 8/25/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amatun Naem, M.D. 40 501 Dolphin St. Balto, md. 21217 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 26 1999 | | 32. Registrar's Signature Benita B. Sparks | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26804

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Hilda E. Young

2. Date of Death

August

Day

21

Year

1999

3. Time of Death

10:05 AM

4a. Facility Name (If not institution, give street and number)

1502 Kenhill Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

214-14-2029

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

8-28-1909

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1502 Kenhill Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic Worker

16b. Kind of Business/Industry

Private Home

17. Father's Name (First, Middle, Last)

Arthur Jenifer

18. Mother's Name (First, Middle, Maiden Surname)

Estelle Curtis

19a. Informant's Name/Relationship (Type, Print)

Doris Campbell - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1502 Kenhill Avenue Baltimore, Md 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cem

Date

8-26-99

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

Bladys Wane

22. Name and Address of Facility

March F.H. West 4300 Wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

Approximate Interval Between Onset and Death

> 2 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
Coronary artery disease

> 5 yrs

Due to (or as a consequence of):
Carcinoma of colon

> 2 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. N. Khan

29c. License number

D25391

29d. Date signed (Month, Day, Year)

8-25-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. KHAN 5601- Loch Raven Blvd, Baltimore MD 21239

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

Anna B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-26805

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLOTTE AMEILA BENDER ABELL

2. Date of Death

Month Day Year
AUGUST 8 1999

3. Time of Death

2:15pm

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System Baltimore

4b. City, Town, or Location of Death

4c. County of Death

Funeral
Director

5. Social Security Number

180-18-8363

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

77

8. Date of Birth

Month Day Year

9. Birthplace (State or Foreign Country)

01/31/1922 Phila., PA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

St. Michaels

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9816 Martingham Circle

10f. Zip Code

21663

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

Charles H. Bender

18. Mother's Name (First, Middle, Maiden Surname)

Henrietta Schwehm

19a. Informant's Name/Relationship (Type, Print)

Ernest G. Abell (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9816 Martingham Circle, St. Michaels, MD 21663

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillside Cemetery

Date

8/13/99

20c. Location - City or Town, State

Roslyn, PA

21. Signature of Funeral Service Licensee

[Signature] CC0315

22. Name and Address of Facility

Beeson Memorial Services

2053 Pulaski Highway, Newark, DE 19702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Left Ventricular Rupture

1 hr.

Due to (or as a consequence of):

b. Post-infarct Ventricular Septal Defect

24 hrs.

Due to (or as a consequence of):

c. Myocardial Infarction

48 hrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kurt Wehberg, Resident

29c. License number

D46536

29d. Date signed (Month, Day, Year)

8/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kurt WEHBERG, M.D. UMMS 22 S. Greene St Baltimore MD 21201

31. Date filed (Month, Day, Year)

AUG 11 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26806

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Estelle Rice Breeden

2. Date of Death

Month August Day 7, Year 1999

3. Time of Death

11:55AM

4a. Facility Name (If not institution, give street and number)

Sutton Motel, 405 East Pulaski Highway

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

229-78-5291

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 27, 1952

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Virginia

10b. County

10c. City, Town or Location

Radford

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

102 H Jeffries Drive

10f. Zip Code

24141

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

in her own home

17. Father's Name (First, Middle, Last)

Arthur Rice

18. Mother's Name (First, Middle, Maiden Surname)

Beulah Christian

19a. Informant's Name/Relationship (Type, Print)

Larry J. Breeden, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

102 H Jeffries Drive, Radford, Virginia 24141

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

West View Cemetery

Date

8/10/99

20c. Location - City or Town, State

Radford, Virginia

21. Signature of Funeral Service Licensee

Donna S. Hicks

22. Name and Address of Facility

Hicks Home for Funerals, P.A.
103 W. Stockton St., Elkton, Maryland 2192123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Atherosclerotic Coronary Vascular Disease years

Due to (or as a consequence of):

b. Insulin Dependent Diabetes years

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Morbid Obesity

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) Motel

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

H. Farkas, MD

29c. License number

D15314

29d. Date signed (Month, Day, Year)

August 7, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Farkas, MD Union Hospital, Elkton, MD

31. Date filed (Month, Day, Year)

AUG 12 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

1891

1892

WRC
99-4568-019
CAROLYN M.
BLAKE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26807

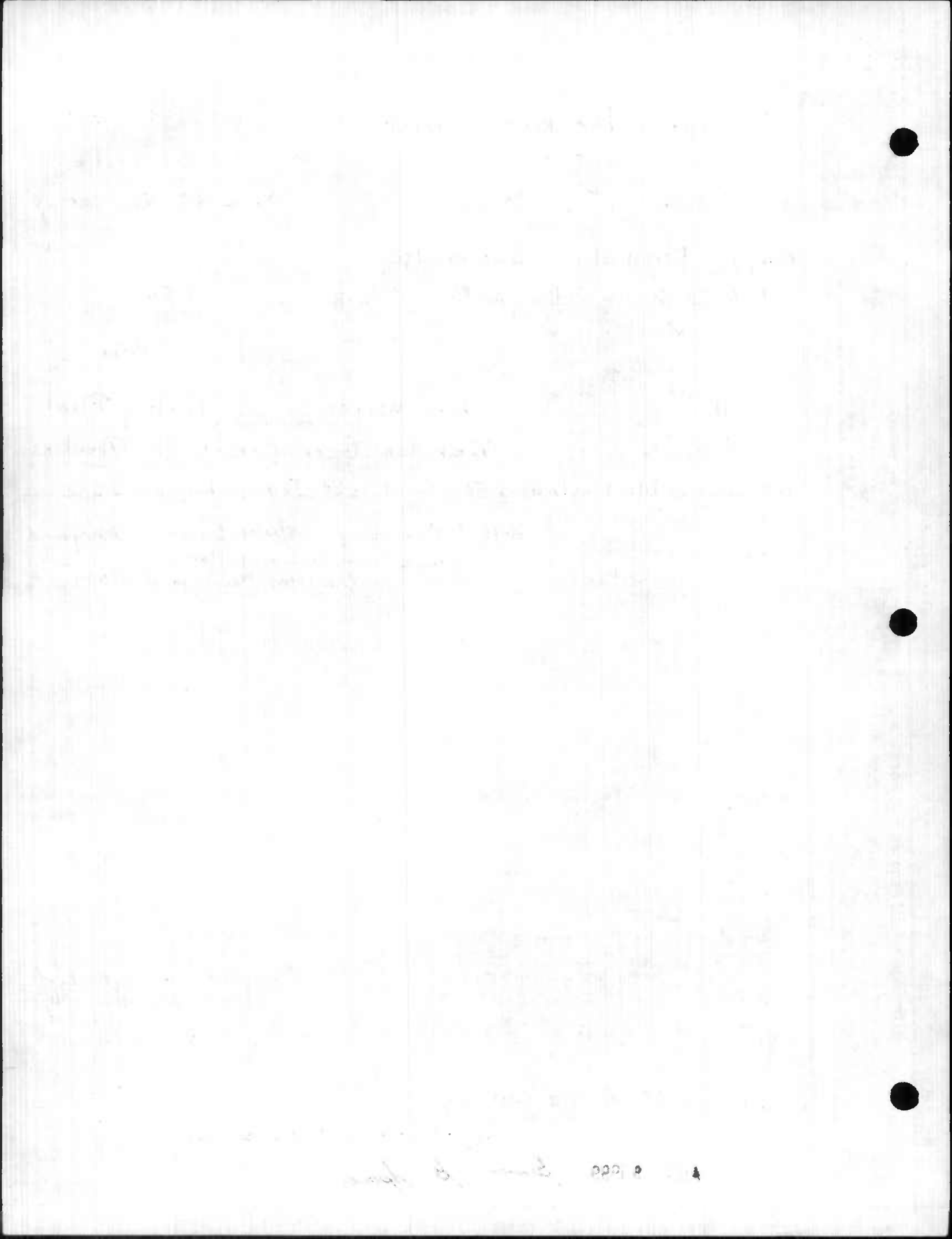
Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Carolyn Meekins Blake | | | | 2. Date of Death Month Day Year AUGUST 04, 1999 | | 3. Time of Death 3:00 AM. | | |
| | 4a. Facility Name (If not institution, give street and number) DORCHESTER GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death CAMBRIDGE | | 4c. County of Death Dorchester | | |
| Funeral Director | 5. Social Security Number 219-70-8315 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 38 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 08-15-60 | 9. Birthplace (State or Foreign Country) New Jersey | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | 10b. County Dorchester | | 10c. City, Town or Location Cambridge | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 2606 Cambridge Beltway Apt. #6 | | 10f. Zip Code 21613 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Line Worker | | 16b. Kind of Business/Industry Poultry Plant | | | | | |
| 17. Father's Name (First, Middle, Last) Louis | | | | 18. Mother's Name (First, Middle, Maiden Surname) Webster Geraldine Meekins | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Geraldine Meekins (mother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 Gardens Ct., Federalsburg, Md. 21632 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bethel Cemetery | | 20c. Date 8/10/99 | | 20d. Location - City or Town, State Cambridge, Maryland | | | |
| 21. Signature of Funeral Service Licensee John A. Prince | | 22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687 Easton, Maryland 21601 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Multiple Stab wounds Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 8-4-99 | | 28b. Time of Injury 0137 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject was stabbed | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Stephen S. Radentz | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 05, 1999 | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 602 Moores Avenue Dorchester, Maryland | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 9 1999 | | 32. Registrar's Signature Beverly B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26808

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GERTRUDE NIEMI BOESCH

2. Date of Death

Month Day Year
August 11, 1999

3. Time of Death

0118

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

380-16-0202

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JAN. 10, 1923

9. Birthplace (State or Foreign Country)

MICHIGAN

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

ST. MICHAELS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

24345 WIDGEON PLACE #29

10f. Zip Code

21663

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

CHARLES NIEMI

18. Mother's Name (First, Middle, Maiden Surname)

HILDA KALLIO

19a. Informant's Name/Relationship (Type, Print)

DAVID S. BOESCH/ HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24345 WIDGEON PLACE #29, ST. MICHAELS, MD 21663

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHESAPEAKE CREMATION CTR.

Date

8-12-99

20c. Location - City or Town, State

STEVENSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A.
200 S. HARRISON ST., EASTON, MD 21601Physician
/Medical
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Adult Respiratory Distress Syndrome

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 WEEKS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Sepsis Syndrome

Due to (or as a consequence of):

3 WEEKS

c. Pneumonia

Due to (or as a consequence of):

3 WEEKS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung Cancer - metastatic to brain
Cerebrovascular accident
Renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D44749

29d. Date signed (Month, Day, Year)

8/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER L. WHITESELL, M.D., 508 IDLEWILD AVENUE, EASTON, MD 21601

State
Registrar

31. Date filed (Month, Day, Year)

AUG 13 1999

32. Registrar's Signature

Gertrude Boesch
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 26809**
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|---|--|---------------------------------|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES VINCENT BULGER | | | | 2. Date of Death Month August Day 13 Year 1999 | | 3. Time of Death 0605 | |
| | 4a. Facility Name (If not institution, give street and number) KENT & QUEEN ANNES HOSPITAL | | | | 4b. City, Town, or Location of Death CHESTERTOWN | | 4c. County of Death KENT | |
| Funeral Director | 5. Social Security Number 190-16-8026 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 80 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 1 1919 | 9. Birthplace (State or Foreign Country) Pennsylvania |
| | Usual Residence of Decedent | | | | 10a. State MD | | 10b. County Kent | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Millington | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 161 Sassafras St. | |
| | 10f. Zip Code 21651 | | | | 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 42/45 | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder | | 16b. Kind of Business/Industry Pennsylvania Military College | |
| | 17. Father's Name (First, Middle, Last) John L. Bulger | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary K. MacNeil | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Donna Blackiston (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 161 Sassafras St. Millington, MD. 21651 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chester Rural Cem. | | 20c. Location - City or Town, State 8/18/99 Upland, PA. | |
| | 21. Signature of Funeral Service Licensed  M00510 | | | | 22. Name and Address of Facility Galena Funeral Home of Stephen Schaech 118 West Cross St. Galena, MD. 21635 | | | |
| | 23a. Part I. Enter the sign(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrest Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. Hypotension Due to (or as a consequence of): d. Supraventricular tachycardia | | | | Approximate Interval Between Onset and Death 1 minute 12 hrs. 14 hrs. 2 wks. | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCAD, HTN, BPH, hyponatremia, methicillin resistant staph. aureus UTI | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  MD | | | | |
| 29c. License number D51735 | | | | 29d. Date signed (Month, Day, Year) 8/13/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick W. Delboy MD 6602 Church Hill Rd. Chestertown, MD. 21620 | | | | 31. Date filed (Month, Day, Year) AUG 16 1999 | | | | |
| 32. Registrar's Signature  | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5-11A

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 26810**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | |
|---|--|---|--------------------------------|--|
| 1. Decedent's Name (First, Middle, Last) Mary Elizabeth Brady | | 2. Date of Death Month August Day 9 Year 1999 | | 3. Time of Death 12:15 PM |
| 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel |
| 5. Social Security Number 577-26-6279 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| Usual Residence of Decedent | | 8. Date of Birth (Month, Day, Year) Sept. 11, 1914 | | 9. Birthplace (State or Foreign Country) Tennessee |
| 10a. State Maryland | 10b. County Anne Arundel | 10c. City, Town or Location Edgewater | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 804 Shore Drive | | 10f. Zip Code 21037 | | 10g. Citizen of What Country? USA |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk | | 16b. Kind of Business/Industry County Government | | |
| 17. Father's Name (First, Middle, Last) Joseph Cysh Hayes | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Agnes Dowell | | |
| 19a. Informant's Name/Relationship (Type, Print) Gail L. Johns / Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 804 Shore Drive, Edgewater, Maryland 21037 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Gardens 8-12-99 Annapolis, Maryland | | 20c. Location - City or Town, State |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Maryland | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Septic Shock Due to (or as a consequence of): Bowel Ischemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. Septic Shock Due to (or as a consequence of): Bowel Ischemia b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 24 hours 24 hours | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | |
| 29c. License number D38445 | | 29d. Date signed (Month, Day, Year) Aug 9th, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Weinstein 600 Ridgely Ave, Annapolis MD | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1999 | | 32. Registrar's Signature | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26811

| | | | | | |
|---|---|--|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LINDA BROWNLEE | | 2. Date of Death Month 8 Day 7 Year 1999 | | 3. Time of Death 11:45 A.M. |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel |
| Funeral Director | 5. Social Security Number 212-74-9287 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 48 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) Jun. 12, 1951 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State Maryland | | 10b. County Anne Arundel |
| | 10c. City, Town or Location Annapolis | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number 12 Bates Street | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? US |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Daycare Provider |
| | 16b. Kind of Business/Industry Homemaker | | 17. Father's Name (First, Middle, Last) Joseph H. Pergerson | | 18. Mother's Name (First, Middle, Maiden Surname) Sarah Smothers |
| | 19a. Informant's Name/Relationship (Type, Print) Terisha Holland (Daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7824 Woodside Terrace Glen Burnie, Md. 21061 | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Annapolis Mem. Gardens | | 20c. Location - City or Town, State 8-12-99 Annapolis, Md. |
| | 21. Signature of Funeral Service Licensee Larry S. Reese | | 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| To Be Completed by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | | a. Respiratory failure 2° Congestive heart failure Due to (or as a consequence of): | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | b. Stage 3 Non small cell lung Cancer Due to (or as a consequence of): | | |
| | | | c. Chronic Renal failure Due to (or as a consequence of): | | |
| | | | d. > 1 year > 6 months | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Internal Medicine | | 29c. License number H005284 3 | | 29d. Date signed (Month, Day, Year) 8-7-99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Peter Swaby 180 Admiral Cochrane Drive Annapolis MD | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 11 1999 | | 32. Registrar's Signature [Signature] | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26812

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|--|---|---|--|--|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ovil Lee BOLLING | | | | 2. Date of Death Month Day Year July 31, 1999 | | | | 3. Time of Death 12:31 am | | |
| | 4a. Facility Name (If not institution, give street and number) 464 Sarah Anne Drive | | | | 4b. City, Town, or Location of Death Lothian | | | | 4c. County of Death Anne Arundel | | |
| Funeral Director | 5. Social Security Number 218 03 4849 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) May 24, 1919 | | 9. Birthplace (State or Foreign Country) VA | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Lothian | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 464 Sarah Anne Drive | | | | 10f. Zip Code 20711 | | | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-44 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Instrument technician | | | | 16b. Kind of Business/Industry Steel | | |
| | 17. Father's Name (First, Middle, Last) Rols Walter Bolling | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ella Jane Herring | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Helen Bolling/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | Date 8-1-99 | | 20c. Location - City or Town, State Alexandria, VA | | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Septic Shock — Urosepsis source Due to (or as a consequence of): b. Obstructive Prostatic Hypertrophy Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death 1 day 2 years. | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation Multi-infarct Dementia and Left Hemiparesis Arteriosclerotic Cardiovascular Disease Cerebrovascular Insufficiency | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Gerald P. Steiner M.D. | | | | 29c. License number D17245 | | 29d. Date signed (Month, Day, Year) July 31, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gerald P. Steiner M.D. Owings, Md 20736 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

12

1 VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26813

| | | | | | | | | |
|--|--|--|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ELIZABETH EMILY BRATTEN | | | | 2. Date of Death Month: August Day: 4 Year: 1999 | | 3. Time of Death 0600 | |
| | 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | |
| Funeral Director | 5. Social Security Number 226-36-7424 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) MAR. 4, 1931 | |
| | 9. Birthplace (State or Foreign Country) VIRGINIA | | 10a. State MARYLAND | | 10b. County WICOMICO | | 10c. City, Town or Location SALISBURY | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 928 S. PARK DR. | | 10f. Zip Code 21804 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) POULTRY GROWER | | 16b. Kind of Business/Industry OWN FARM | | | |
| | 17. Father's Name (First, Middle, Last) AARON J. CAMPBELL | | 18. Mother's Name (First, Middle, Maiden Surname) MAMIE HUNLEY | | 19a. Informant's Name/Relationship (Type, Print) LORIE BRATTEN CORROR - DAUGHT. | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 928 S. PARK DR. SALISBURY, MD 21804 | |
| Physician /Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) SPRINGHILL MEMORY GARDEN | | 20c. Location - City or Town, State HEBRON, MARYLAND | | 20d. Date 8/6/99 | |
| | 21. Signature of Funeral Service Licensee B. Keeney | | 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory failure Due to (or as a consequence of): Aspiration pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dementia Alzheimers Type | | Approximate Interval Between Onset and Death 2 days 2 days | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once. | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| State Registrar | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Christion Huddleston | | 29c. License number D29105 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christion Huddleston, M.D. 106 Milford St. Salisbury, MD | | | | 29d. Date signed (Month, Day, Year) 8/4/99 | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | | | 32. Registrar's Signature Geneva B. Sparks | | | | |

THE CITY OF BOSTON, MASSACHUSETTS, WAS FOUNDED IN 1630 BY THE PURITAN LEADERS OF THE MASSACHUSETTS BAY COLONY.

THE CITY WAS FIRST KNOWN AS BOSTONIA, AND LATER AS BOSTON.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26814

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WOODROW

W.

BROBST

2. Date of Death

August 10 1999

3. Time of Death

8:10 a.m.

Funeral
Director

4e. Facility Name (If not institution, give street and number)

BERLIN NURSING & REHABILITATION CENTER

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

5. Social Security Number

190-14-2501

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

FEB. 3, 1919

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WORCESTER

10c. City, Town or Location

BERLIN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10218 OLD OCEAN CITY BLVD.

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1944-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

BUTCHER

16b. Kind of Business/Industry

FOOD

17. Father's Name (First, Middle, Last)

FLOYD

BROBST

18. Mother's Name (First, Middle, Maiden Surname)

MAME

YOUNG

19a. Informant's Name/Relationship (Type, Print)

BETTY DAVIS BROBST/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 241, BISHOPVILLE, MARYLAND 21813

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MILLSBORO CEMETERY

Date

8/12/99

20c. Location - City or Town, State

MILLSBORO, DELAWARE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Renal Failure 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetic nephropathy years.

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Dialysis Discontinued.
Old Cerebro Vascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D02026

29d. Date signed (Month, Day, Year)

August 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Federico G. Arthes, M.D., 46 Teal Circle, Berlin, MD 21811

31. Date filed (Month, Day, Year)

AUG 12 1999

32. Registrar's Signature

[Signature]

State
RegistrarWOODROW BROBST
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten text at the bottom of the page, possibly a signature or date, appearing to read "March 2 - 1904".

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26815

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Donald Wesley BIVENS, Jr. | | | | | 2. Date of Death August 5, 1999 | | 3. Time of Death 9:20 am | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 218 54 8394 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 50 Yrs. | 8. Date of Birth (Month, Day, Year) Dec. 17, 1948 | 9. Birthplace (State or Foreign Country) Wash., DC | | | | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Prince George's | 10c. City, Town or Location Upper Marlboro | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 15408 Marlboro Pike | | | 10f. Zip Code 20772 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) warehouse manager | | 16b. Kind of Business/Industry beer distributor | | | | |
| | 17. Father's Name (First, Middle, Last) Donald Wesley Bivens, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Lewis | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Debora Fowler Kelly (cousin) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5959 Rose Court, St. Leonard, MD 20685 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery | | 20c. Location - City or Town, State Clinton, MD | | 20d. Date 8-7-99 | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) a. <u>Cerebrovascular accident</u> Due to (or as a consequence of): b. <u>Cerebral hemorrhage</u> Due to (or as a consequence of): c. <u>Fever</u> Due to (or as a consequence of): d. <u>Leukocytosis</u> | | | | | | | | <u>days</u> <u>days</u> <u>days</u> <u>days</u> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <u>Hung Davis</u> | | 29c. License number D53111 | | 29d. Date signed (Month, Day, Year) 8/5/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUNG DAVIS Anne Arundel Medical Ctr. ANNAPOLIS, MD 21401 64 FRANKLIN ST | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 06 1999 | | 32. Registrar's Signature <u>James B. Sparks</u> | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26816

| | | | | | | | | | | |
|--|---|--|--|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HARVEY RAYMOND CUSTIS | | | | 2. Date of Death Month Day Year AUGUST 14 1999 | | | | 3. Time of Death 7:30AM | |
| | 4a. Facility Name (If not institution, give street and number) 7130 POORHOUSE ROAD | | | | 4b. City, Town, or Location of Death LA PLATA | | | | 4c. County of Death CHARLES | |
| Funeral Director | 5. Social Security Number 214-28-5688 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 69 Yrs. | | 8. Date of Birth (Month, Day, Year) OCT. 18, 1929 | | 9. Birthplace (State or Foreign Country) ARDMORE, PA | |
| | Usual Residence of Decedent | | | | 10a. State MARYLAND | | 10b. County CHARLES | | 10c. City, Town or Location LA PLATA | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 7130 POORHOUSE ROAD | | | | 10f. Zip Code 20646 | |
| | 10g. Citizen of What Country? UNITED STATES | | | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4+ | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PASTOR | | | | 16b. Kind of Business/Industry MINISTER | | | | 17. Father's Name (First, Middle, Last) RAYMOND CUSTIS | |
| | 18. Mother's Name (First, Middle, Maiden Surname) ANNIE MARIE ROBINSON CUSTIS | | | | 19a. Informant's Name/Relationship (Type, Print) LE VURN CUSTIS / WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7130 POORHOUSE ROAD LA PLATA, MARYLAND 20646 | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WEST LIBERTY CHURCH CEM. | | | | 20c. Location - City or Town, State 8/20/99 MARIOTTSTVILLE, MD | |
| | 21. Signature of Funeral Service Licensee  LEON THORNTON | | | | 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD INDIAN HEAD, MD 20640 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PROSTATE CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury M | | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  M. Mathur | | | | 29c. License number D28352 | | |
| 29d. Date signed (Month, Day, Year) AUGUST 16, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KRISHAN MATHUR, MD., P.O. BOX 1703, LA PLATA, MD 20646 | | | | 31. Date filed (Month, Day, Year) AUG 17 1999 | | |
| 32. Registrar's Signature  | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26817

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|-------------------------------|--|--|---|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edward Jack Cosgrove | | | | 2. Date of Death Month Day Year August 11, 1999 | | | | 3. Time of Death 3:05 am | |
| | 4a. Facility Name (If not institution, give street and number) Future Care - Chesapeake | | | | 4b. City, Town, or Location of Death Arnold | | | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 044-16-1452 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) Jul 15, 1923 | | 9. Birthplace (State or Foreign Country) New York | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State NC | | 10b. County Moore | | 10c. City, Town or Location Pinehurst | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 117 Foxfire Drive | | | | 10f. Zip Code 28374 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager | | | 16b. Kind of Business/Industry Medical Supplies | | |
| | 17. Father's Name (First, Middle, Last) Unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sadie Broodhead | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Ken Cosgrove/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Edgewater Lane Severna Park, MD 21146 | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date Aug 11 1999 | | 20c. Location - City or Town, State Baltimore, MD | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Barranco & Sons, P.A. Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Right Middle Cerebral Artery Stroke months Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Coronary Artery Disease, dysphagia, aphasia gastrostomy tube feeding | | | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier | | | | 29c. License number D4A955 | | 29d. Date signed (Month, Day, Year) 8-11-99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aberca Elon MD 479 Jumpers Hole Road Severna Park MD 21146 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1999 | | 32. Registrar's Signature | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint, illegible handwritten text]

AND 1 2 1000

99 26818

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Ralph Crowner | | | | 2. DATE OF DEATH MONTH DAY YEAR 8 12 1999 | | 3. TIME OF DEATH 7:25 A.M. | |
| 4. SOCIAL SECURITY NUMBER 213-05-0015 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 13, 1920 | |
| 9a. FACILITY NAME (If not institution, give street and number) Millennium Health & Rehab | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Edgewater | | 9c. COUNTY OF DEATH Anne Arundel | |
| 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Annapolis | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 701 Glenwood St. | | | | 10f. ZIP CODE 21401 | | 10g. CITIZEN OF WHAT COUNTRY? US | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waterman | | 16b. KIND OF BUSINESS/INDUSTRY Self Employed | | | |
| 17. FATHER'S NAME (First, Middle, Last) Robert Crowner Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elenor Davis | | | |
| 19a. INFORMANT'S NAME (Type/Print) Elenor Cobbs (Sister) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5200 12th St. N.E. Washington D.C. 20011 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Annapolis Memorial Gardens | | 20c. LOCATION — City or Town, State Annapolis | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry S. Reese</i> | | | | 22. NAME AND ADDRESS OF FACILITY Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive heart failure Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Obstructive sleep apnea a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death 24 yrs 6 mon |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Type 2 Diabetes mellitus Hypertension cardiomyopathy | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURED | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donna Chambers MD</i> | | 29c. LICENSE NUMBER D48101 | | 29d. DATE SIGNED (Month, Day, Year) 8/12/99 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Donna Chambers MD 1833A Forest Dr Annapolis MD 21401 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) AUG 16 1999 | | 32. REGISTRAR'S SIGNATURE <i>Larry S. Reese</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

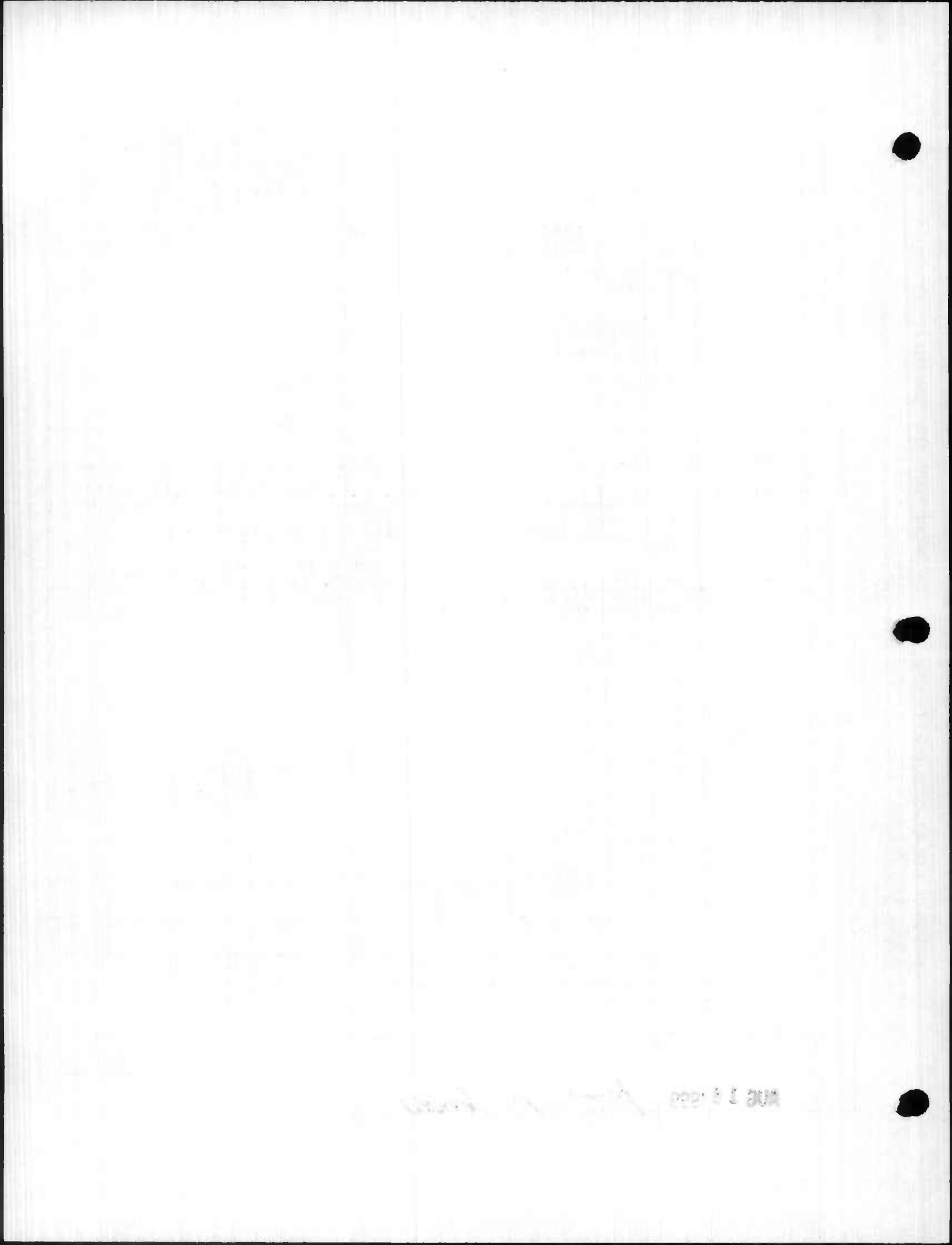
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26819

| | | | | | | | | |
|--|---|---|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOSHUA ISAAC CRUZ | | | | 2. Date of Death Month Day Year JUL 22 1999 | | 3. Time of Death 5:55 AM | |
| | 4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death BETHESDA | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number N/A | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) Yrs. 16 | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 6, 1999 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County P.G. | | 10c. City, Town or Location Andrews Air Force Base | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 2078 B Tucson Ave | | | | 10f. Zip Code 20762 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Portugese | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A | | | 16b. Kind of Business/Industry N/A | |
| 17. Father's Name (First, Middle, Last) Billy Cruz | | | | 18. Mother's Name (First, Middle, Maiden Surname) Christy Boldin | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Billy Cruz (FATHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2078 B Tucson Ave, Andrews Air Force Base, MD 20762 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory | | Date July 24, 1999 | | 20c. Location - City or Town, State Clinton, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. SMITH-LEMLI-OPITZ SYNDROME Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | | | | | |
| 29c. License number D-41551 | | 29d. Date signed (Month, Day, Year) 07/23/99 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUSSELL R. MOORES, JR., LTC, MC, USA | | | | NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 | | | | |
| 31. Date filed (Month, Day, Year) JUL 26 1999 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

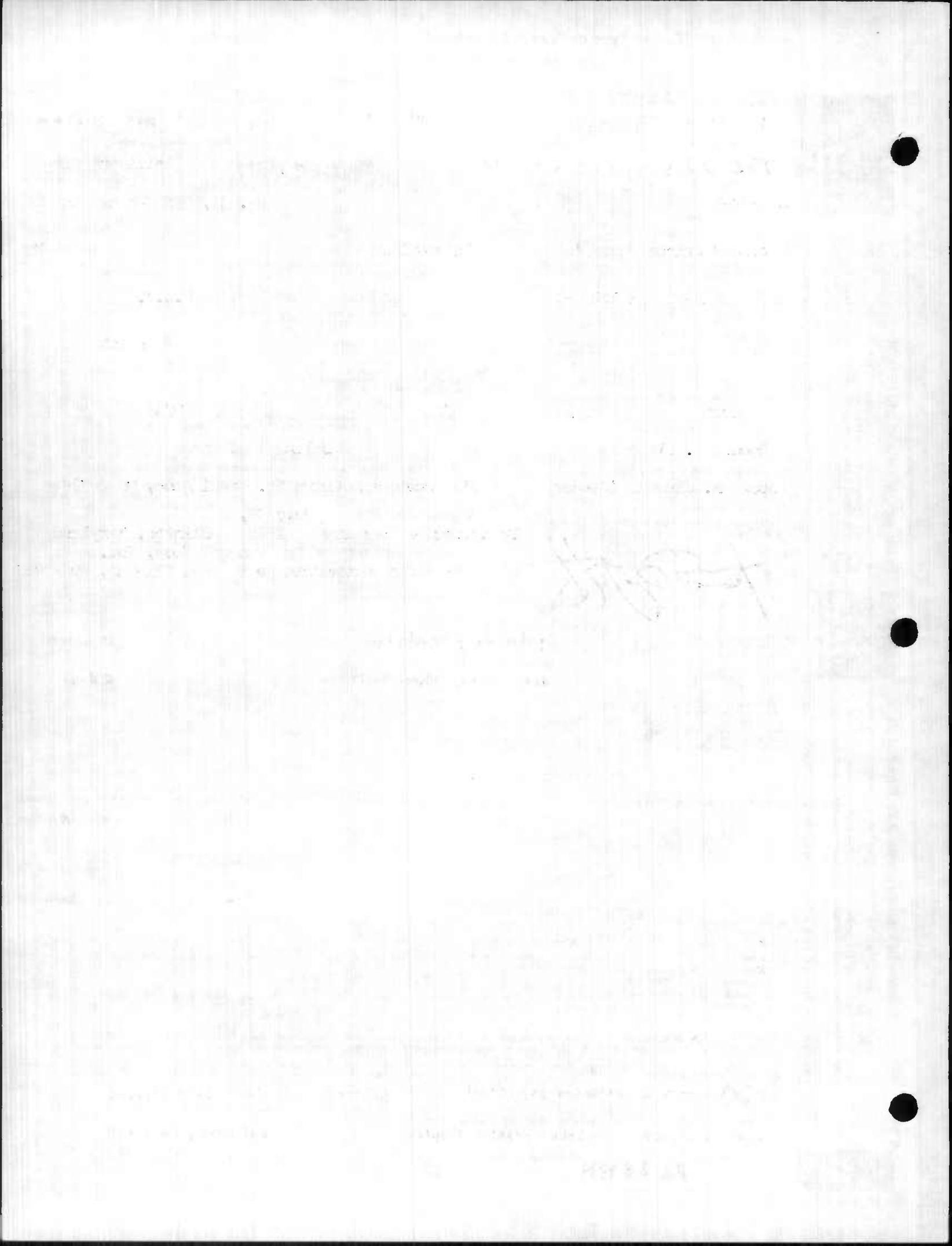
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

09 26820

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26821

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Richard Collins | | | | 2. Date of Death Month July Day 21 , Year 1999 | | 3. Time of Death 0525 |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel |
| Funeral Director | 5. Social Security Number 213-34-4433 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 68 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours | 8. Date of Birth (Month, Day, Year) Dec. 13, 1930 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Edgewater | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 445 Collins Road | | | | 10f. Zip Code 21037 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | 16b. Kind of Business/Industry State Highway | |
| 17. Father's Name (First, Middle, Last) Samuel Thomas Collins | | | | 18. Mother's Name (First, Middle, Maiden Surname) Edith L. Brown | | | |
| 19a. Informant's Name/Relationship (Type, Print) Charles D. Collins/Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 445 Collins Road Edgewater, MD 21037 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chews UM Church Cem. | | 20c. Date 7/27/99 | | 20d. Location - City or Town, State West River, MD | |
| 21. Signature of Funeral Service Licensee Blacks G. Sewell | | | | 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. thrombocytopenia Due to (or as a consequence of): d. Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death days days days years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier H. Davis, MD | | | | 29c. License number D53111 | | 29d. Date signed (Month, Day, Year) 7/21/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hung T. Davis, M.D. AAMC 64 Franklin St. Annapolis, MD 21401 | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 26 1999 | | 32. Registrar's Signature B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26822

| | | | | | | | | |
|---|---|--|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marion E. Cole | | | | 2. Date of Death July 21, 1999 | | 3. Time of Death 905 PM | |
| | 4a. Facility Name (If not institution, give street and number) Solomons Nursing Center | | | | 4b. City, Town, or Location of Death Solomons | | 4c. County of Death Calvert | |
| Funeral Director | 5. Social Security Number 577 07 5600 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 | If Under 1 Year Months | If Under 24 Hrs. Days | 8. Date of Birth (Month, Day, Year) May 10 1907 | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Calvert | | 10c. City, Town or Location Solomons | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 13325 Dowell Road | | | | 10f. Zip Code 20688 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) office manager | | | 16b. Kind of Business/Industry communications | |
| | 17. Father's Name (First, Middle, Last) unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname) unknown | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Perry Bowen- Executor | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5930 Sheridan Pt. Rd. Prince Frederick MD 20678 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Funeral Service | | Date July 22 1999 | | 20c. Location - City or Town, State Alexandria Virginia | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ALZHEIMER'S DEMENTIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier A T Mena M.D. Physn. | | | | 29c. License number D 15427 | | 29d. Date signed (Month, Day, Year) 7/22/99 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 22 1999 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26823

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|--|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marie R. Campli | | | | 2. Date of Death Month July 31, Year 1999 | | 3. Time of Death 5:00 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number) Kris - Leigh Assisted Living Home | | | | 4b. City, Town, or Location of Death Davidsonville | | 4c. County of Death Anne Arundel | | |
| Funeral Director | 5. Social Security Number 116-12-1570 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) July 13, 1913 | | |
| | 9. Birthplace (State or Foreign Country) New York | | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Lothian | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 1007 Lee Jackson Drive | | 10f. Zip Code 20711 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry At Home | | | |
| 17. Father's Name (First, Middle, Last) Thomas Reilly | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Carpenter | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Arthur R. Campli (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1007 Lee Jackson Drive, Lothian, Maryland 20711 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery | | Date 8/2/99 | | 20c. Location - City or Town, State Clinton, Maryland | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial infarction Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 1 hour | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Gangrenous Cholecystitis | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Paul S Rhodes MD | | 29c. License number 22028 | | 29d. Date signed (Month, Day, Year) 8 2 99 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Paul Rhodes | | 31. Data filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a description of the experimental design, the data collection procedures, and the statistical methods used for data analysis.

3. The third part of the report is a presentation of the results of the study. It includes a description of the data, a discussion of the findings, and a comparison of the results with previous research.

4. The fourth part of the report is a conclusion and a discussion of the implications of the study. It includes a summary of the findings, a discussion of the limitations of the study, and a discussion of the implications of the results for future research.

5. The fifth part of the report is a list of references. It includes a list of the books, articles, and other sources used in the study.

6. The sixth part of the report is an appendix. It includes a list of the tables, figures, and other materials used in the study.

7. The seventh part of the report is a list of figures. It includes a list of the figures used in the study.

8. The eighth part of the report is a list of tables. It includes a list of the tables used in the study.

9. The ninth part of the report is a list of abbreviations. It includes a list of the abbreviations used in the study.

10. The tenth part of the report is a list of symbols. It includes a list of the symbols used in the study.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26824

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James Morris Cook, Jr. | | | | 2. Date of Death Month Day Year July 28 1999 | | 3. Time of Death 707 PM | |
| | 4a. Facility Name (If not institution, give street and number) 50 Appeal Lane Apt. 322 | | | | 4b. City, Town, or Location of Death Lusby | | 4c. County of Death Calvert | |
| Funeral Director | 5. Social Security Number 219 36 9428 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 59 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug 28 1939 | |
| | 9. Birthplace (State or Foreign Country) West Virginia | | 10a. State Maryland | | 10b. County Calvert | | 10c. City, Town or Location Lusby | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 50 Appeal Lane Apt. 322 | | 10f. Zip Code 20657 | |
| | 10g. Citizen of What Country? United States | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 57 | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) truck driver | | | | 16b. Kind of Business/Industry Transportation | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) James Morris Cook, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Madeline Leggett | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Nora M. Cook- wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 50 Appeal Lane Apt. 322 Lusby Md 20657 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery | | | |
| | 20c. Location - City or Town, State Cheltenham Maryland | | | | 21. Signature of Funeral Service Licensee B. Rausch | | | |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility Rausch Funeral Home pA 4405 Broomes Is. rd. Port Republic MD 20670 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 4 months | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier M. Ashraf MBELE MD 29c. License number D46246 29d. Date signed (Month, Day, Year) July 30 1999 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. ASHRAF MBELE MD WALDOLF MD 20603 | | | | 31. Date filed (Month, Day, Year) JUL 30 1999 | | | |
| | 32. Registrar's Signature B. Sparks | | | | State Registrar | | | |

6

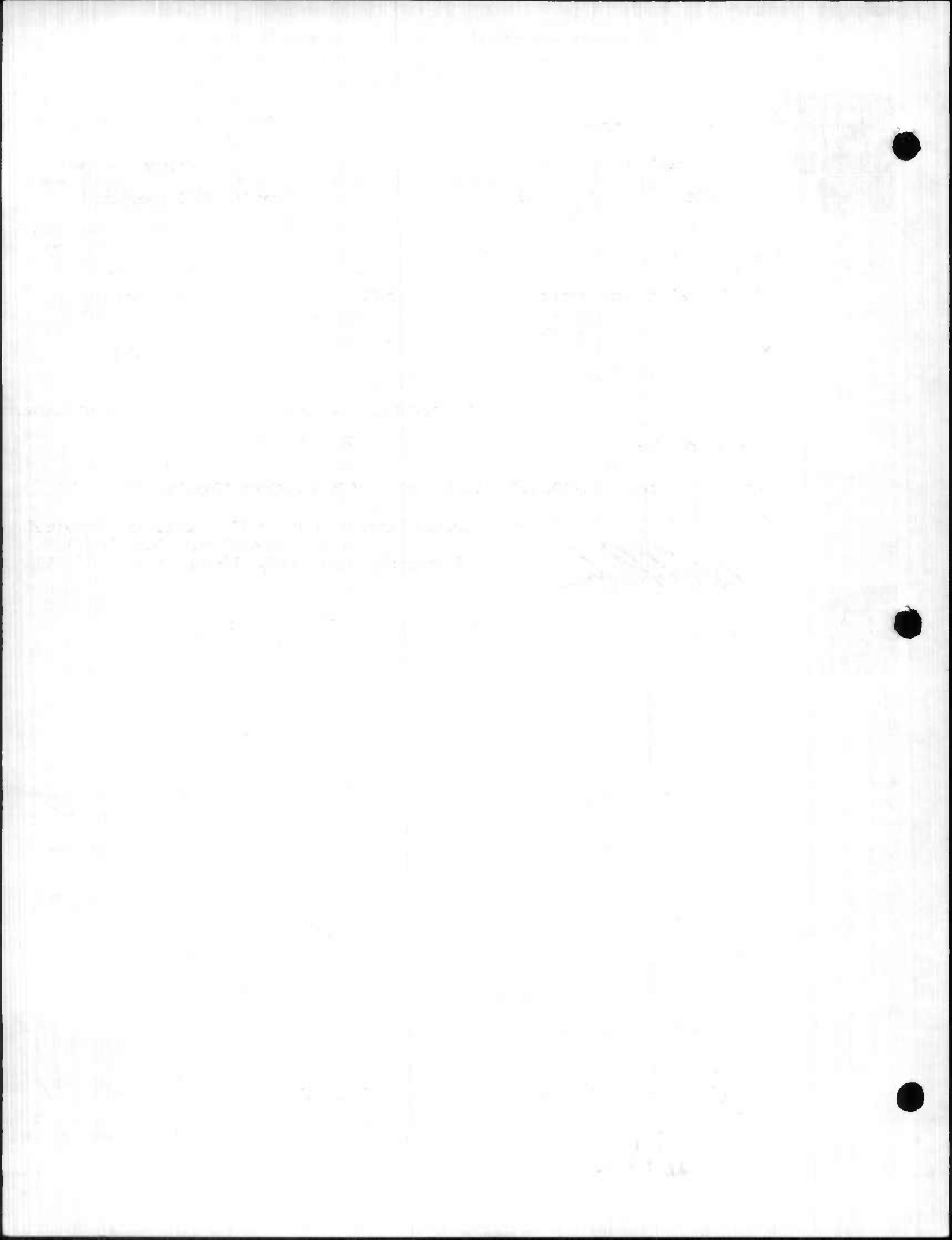
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26825

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Nettie S. Carver | | | | 2. Date of Death Month July Day 25 Year 1999 | | 3. Time of Death 11:20 PM | |
| | 4a. Facility Name (If not institution, give street and number) 15005 Health Care Center | | | | 4b. City, Town, or Location of Death Bowie | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 578 05 0072 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 97 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov 10, 1901 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County P.G. | | 10c. City, Town or Location Bowie | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 15005 Health Care Center | | | | 10f. Zip Code 20716 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Stenographer Retired | | 16b. Kind of Business/Industry D.C. Chamber of Commerce | | |
| 17. Father's Name (First, Middle, Last) Samuel Brookbank | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ruth Knott | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Barbara T. Shields (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10450 Lottsford Road, Mitchellville, MD 20721 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery July 29, 1999 Brentwood, Maryland | | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. congestive heart failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate interval Between Onset and Death months. |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D41978 | | 29d. Date signed (Month, Day, Year) 7-26-99 | | |
| 30. Name and address of person who sampled cause of death (Item 23e) (Type, Print) Nader Savakoli PG & Cheryl M.D 20785 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 29 1999 | | | | 32. Registrar's Signature | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26826

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Helen Cook

2. Date of Death

Month

Day

Year

1624

1624

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

216-38-8246

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 24 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1606 Waciona Drive

10f. Zip Code

21801

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

John Brown SR.

18. Mother's Name (First, Middle, Maiden Surname)

Helen Leatherbury

19a. Informant's Name/Relationship (Type, Print)

Aaron Cook (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

713 Rose Street Salisbury, Md. 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Polks Rd. Cemetery

Date

8/4/99

20c. Location - City or Town, State

Princess Anne, Md.

21. Signature of Funeral Service Licensee

Bladys B. Stewart

22. Name and Address of Facility

Stewart Funeral Home
821 West Rd. Salisbury, Md. 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Atherosclerosis

Due to (or as a consequence of):

Cardiogenic Shock

Due to (or as a consequence of):

Ischemic cardiomyopathy

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Chyford J. Raab MD

29c. License number

29d. Date signed (Month, Day, Year)

8/9/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chyford J. Raab MD 400 Eastern Shore Dr Salisbury MD 21801

31. Date filed (Month, Day, Year)

AUG 11 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitMary H. Cook
216 38 8246
Baltimore, Maryland 21215-0026
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amend #26 WCHD 8/11/99 cle

Reg. No.

99 26827

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

LEANORA FRANCES CHANCEY

2. Date of Death

Month Day Year
AUGUST 10, 1999

3. Time of Death

6:10A.M.

4a. Facility Name (If not institution, give street and number)

HOMESTEAD MANOR

4b. City, Town, or Location of Death

DENTON

4c. County of Death

CAROLINE

5. Social Security Number

218-34-7516

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG. 31, 1912

9. Birthplace (State or Foreign Country)

W. VIRGINIA

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

SEAFORD

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

RT 2 BOX 329D

10f. Zip Code

19973

10g. Citizen of What Country?

AMERICA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YRS.

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BRIGADIER

16b. Kind of Business/Industry

SALVATION ARMY

17. Father's Name (First, Middle, Last)

CHARLES FOGGIN

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE ATHEY FOGGIN

19a. Informant's Name/Relationship (Type, Print)

PHYLLIS J. COULBOURNE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RT 2 BOX 329D SEAFORD, DELAWARE 19973

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WICOMICO MEMORIAL PARK

Date

8/13/99

20c. Location - City or Town, State

SALISBURY, MARYLAND

21. Signature of Funeral Service Licensee

Phyllis J. Coulbourne

22. Name and Address of Facility

WATSON-YATES FUNERAL HOME
FRONT & KINGS STS, SEAFORD, DELAWARE 19973

23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dehydration

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dementia

Due to (or as a consequence of):

c. Hypothyroidism

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Phyllis J. Coulbourne MD

29c. License number

D0011532

29d. Date signed (Month, Day, Year)

8/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jorge Abrego, MD 10 Box 660 Denton MD 21629

31. Date filed (Month, Day, Year)

AUG 11 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

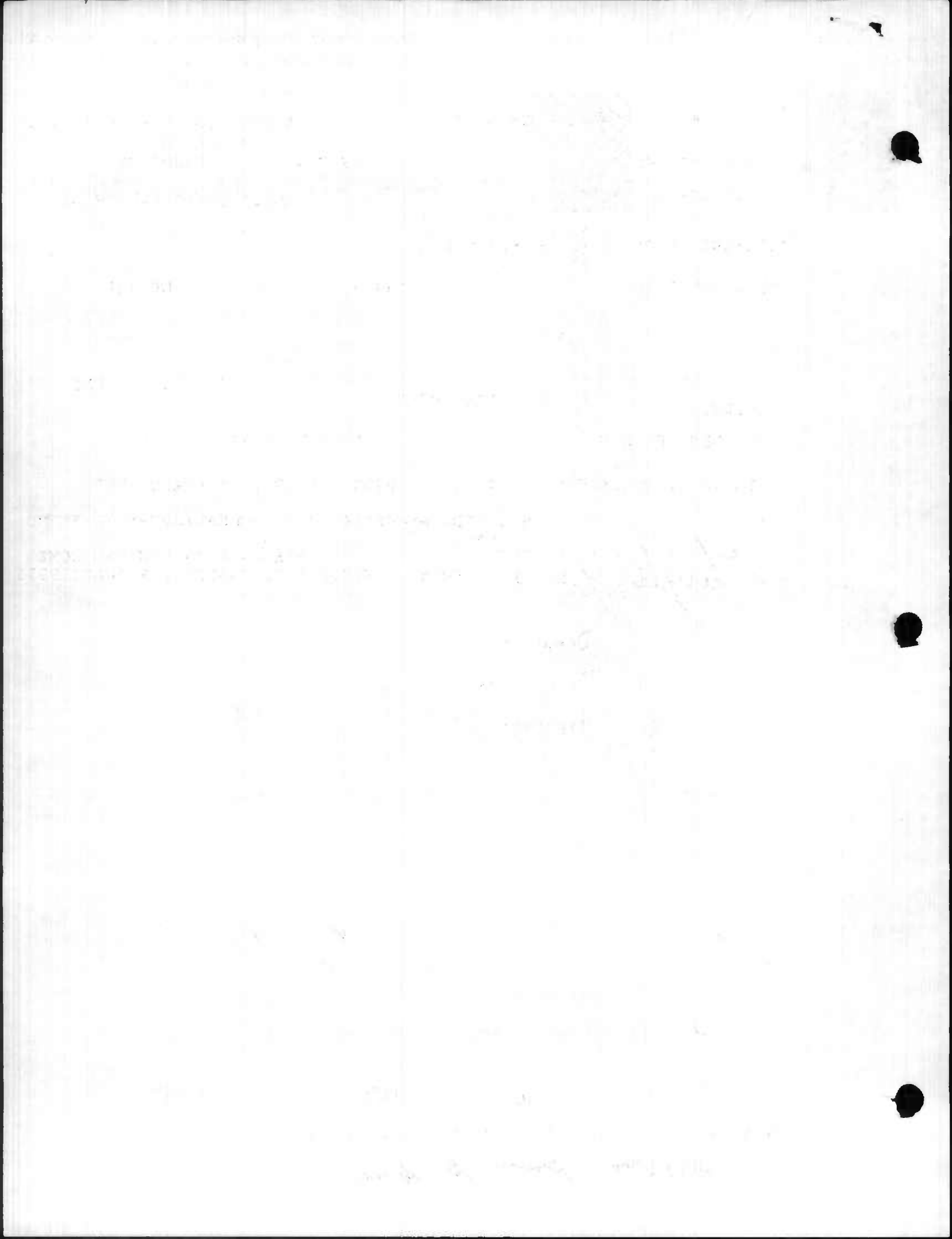
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26828

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|--|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOHN | | 2. Date of Death Month Day Year DUGAS, JR AUGUST 10 1999 | | 3. Time of Death 03:02AM |
| | 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death |
| Funeral Director | 5. Social Security Number 372-30-1340 | 6. Sex 1 M 2 F | 7. Age (In yrs. last birthday) 67 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) JUL 30 1932 | | 9. Birthplace (State or Foreign Country) Michigan | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Severna Park |
| | 10d. Inside City Limits 1 Yes 2 No | | | | |
| | 10e. Street and Number 510 Baltimore Annapolis Blvd. | | 10f. Zip Code 21146 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1950-1971 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) United States Air Force | | 16b. Kind of Business/Industry Military |
| | 17. Father's Name (First, Middle, Last) John Dugas, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname) Marie Garvin | | |
| | 19a. Informant's Name/Relationship (Type, Print) Joan Dugas / Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Baltimore Annapolis Blvd. Severna Park, MD 21146 | | |
| | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | 20c. Location - City or Town, State Baltimore, MD |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PROFOUND METABOLIC ACIDOSIS Due to (or as a consequence of): b. SEPSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 5 DAYS 3 DAYS |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CANCER RADIATION THERAPY | | | | 23c. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown |
| | 24a. Was an autopsy performed? 1 Yes 2 No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |
| | 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | |
| | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No | | |
| 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 2 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier ► Amanda Bid MD | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) AUGUST TENTH, 1999 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOLANDA ZICKMANN JOHNS HOPKINS HOSPITAL, 600 N. WOLFE STREET BALTIMORE, MD 21287 | | | | |
| | 31. Date filed (Month, Day, Year) AUG 16 1999 | | 32. Registrar's Signature | | |

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JUN 1 6 1958

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26829

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGIE MAE DIXON

2. Date of Death
Month Day Year

August

4

1999

3. Time of Death

6:30 pm

4a. Facility Name (If not institution, give street and number)

BERLIN NURSING AND REHABILITATION CENTER

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

Funeral
Director

5. Social Security Number

217-30-7883

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

MAY 10, 1918

9. Birthplace (State or Foreign Country)

SNOWHILL, MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

WORCESTER

10c. City, Town or Location

SNOWHILL

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7049 SHOCKLEY ROAD,

10f. Zip Code

21863

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFRO-AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

HOUSEKEEPER

17. Father's Name (First, Middle, Last)

TEAMER DIXON, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MARTHA TAYLOR

19a. Informant's Name/Relationship (Type, Print)

LEWIS DIXON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8905 IRONSHIRE ROAD, (STATION), BERLIN, MD. 21811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. JAMES AME CHURCH CEM.

Date

8-12

20c. Location - City or Town, State

SNOWHILL, MD.

21. Signature of Funeral Service Licensee

Loretta B. Jolley

22. Name and Address of Facility JOLLEY MEMORIAL CHAPEL

1213 JERSEY ROAD, SALISBURY, MD. 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Heart Failure 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease 2 years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Rectal Bleeding - not specific

Diagnosed

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Loretta B. Jolley

29c. License number

D02026

29d. Date signed (Month, Day, Year)

August 6, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Federico G. Arthes, M.D., 46 Teal Circle, Berlin, MD 21811

State
Registrar

31. Date filed (Month, Day, Year)

AUG 11 1999

32. Registrar's Signature

Loretta B. Jolley

ORIGINAL

Handwritten signature and date: 10/1/2010

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26830

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---------------------------------|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Emily Truitt Duley | | | | 2. Date of Death Month Day Year Aug 9, 1999 | | 3. Time of Death 8:30 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) Calvert House 14711 Mt. Calvert Road | | | | 4b. City, Town, or Location of Death Upper Marlboro | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 213-38-1914 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 91 Yrs. | If Under 1 Year Month Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb 6, 1908 | 9. Birthplace (State or Foreign Country) Snow Hill, MD |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Virginia | | 10b. County Lancaster | | 10c. City, Town or Location Merry Point | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 236 River's Bend Road | | | | 10f. Zip Code 22513 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 5 + | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | | 16b. Kind of Business/Industry P.G. County Schools | |
| 17. Father's Name (First, Middle, Last) William Truitt | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Griffin | | | |
| 19a. Informant's Name/Relationship (Type, Print) Barbara Shanklin(DAUGHTER) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 122 Merry Point, Virginia 22513 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Episcopal Cemetery | | 20c. Location - City or Town, State Upper Marlboro, MD | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiac Arrest Due to (or as a consequence of): Atherosclerotic Cardiovascular Dis Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | Approximate interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Stroke - multiple | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number 002259 | | 29d. Date signed (Month, Day, Year) Aug 11, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rene Grace MD 951 Discatany Rd Clinton, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | | | 32. Registrar's Signature | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

State
Registrar

[Faint, illegible text covering the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26831

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Virginia Grant Davenport | | | | 2. Date of Death Month August 8, Day 1999 Year | | 3. Time of Death 1:50 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) 11450 Asbury Circle Apt. #419 | | | | 4b. City, Town, or Location of Death Solomons | | 4c. County of Death Calvert | |
| Funeral Director | 5. Social Security Number 015-20-0765 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 31, 1922 | |
| | 10e. State Maryland | | 10b. County Calvert | | 10c. City, Town or Location Solomons | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number 11450 Asbury Circle Apt. #419 | | | | 10f. Zip Code 20688 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 Collega (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant | | 16b. Kind of Business/Industry Education / University | |
| | 17. Father's Name (First, Middle, Last) Gordon Grant | | | | 18. Mother's Name (First, Middle, Maiden Surname) Jesse Green | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Amy De Vos (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1355 Fowler Road, Owings, Maryland 20736 | | | |
| | 20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory Aug. 9, 1999 | | 20c. Location - City or Town, State Clinton, Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee D. S. S. S. | | | | 22. Name and Address of Facility Lee Funeral Home, Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Non-Hodgkin's Lymphoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 19 months | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| To Be Completed by Physician/Medical Examiner | 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 29b. Signature and title of certifier Bruce A. Silver, MD | | | | 29c. License number 021463 | | 29d. Date signed (Month, Day, Year) 8-9-99 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Bruce A. Silver, MD 110 Hospital Road, Suite 110, Prince Frederick, MD 20678 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 09 1999 | | | | 32. Registrar's Signature B. Sparks | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26832

Amend #19a WCHD 08/11/99 cle

Certificate of Death

Reg. No.

| | | | | | |
|--|--|---|---|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Lois Almeta Evans | | 2. Date of Death Month Day Year August 4, 1999 | | 3. Time of Death 3:40 AM |
| | 4a. Facility Name (If not institution, give street and number) Salisbury Center: Genesis ElderCare | | 4b. City, Town, or Location of Death Salisbury, MD | | 4c. County of Death Wicomico |
| Funeral Director | 5. Social Security Number 218-16-7519 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 75 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) December 5, 1923 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | | 10b. County Wicomico | | 10c. City, Town or Location Salisbury | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 200 Civic Ave. | | | 10f. Zip Code 21804 | | 10g. Citizen of What Country? USA |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+) - | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Domestic | |
| 17. Father's Name (First, Middle, Last) Otto Hudson Short | | | 18. Mother's Name (First, Middle, Maiden Summa) Grace Meta Truitt | | |
| 19a. Informant's Name/Relationship (Type, Print) Howard E. Evans/Husband | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1, Box 459A, Delmar, DE 19940 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Odd Fellows Cemetery | | 20c. Location - City or Town, State Laurel, DE | |
| 21. Signature of Funeral Service Licensee David A. Thompson MD1051 | | 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. History of strokes Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Heart insufficiency History of strokes | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier [Signature] | | 29c. License number D39813 | | 29d. Date signed (Month, Day, Year) 8/4/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Kins 1104 Webbington Drive, Salisbury MD 21804 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 06 1999 | | 32. Registrar's Signature [Signature] | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

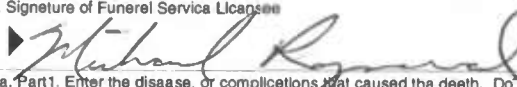
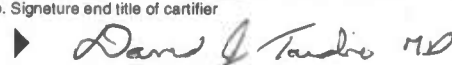
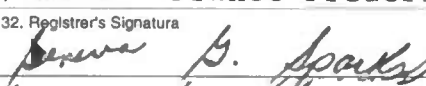
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26833

Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ALBERT Armas ENGLUND | | 2. Date of Death Month AUGUST Day 3 Year 1999 | | 3. Time of Death 20:10 |
| | 4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital | | 4b. City, Town, or Location of Death Pr. Frederick | | 4c. County of Death Calvert |
| Funeral Director | 5. Social Security Number 098-09-8202 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 86 Yrs. | 8. Date of Birth (Month, Day, Year) 3/27/13 | |
| | 9. Birthplace (State or Foreign Country) New York | | 10a. State MD | | |
| To Be Completed by Funeral Director | 10b. County Calvert | | 10c. City, Town or Location Prince Frederick | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number 470 W. Dares Beach Road #413 | | 10f. Zip Code 20678 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Printer | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Printer | | 16b. Kind of Business/Industry U.S. Government | | |
| | 17. Father's Name (First, Middle, Last) Edward Englund | | 18. Mother's Name (First, Middle, Maiden Surname) Edith Rosenquist | | |
| | 19a. Informant's Name/Relationship (Type, Print) Nancy Booth/daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2645 Hidden Hill Ct. Huntingtown, MD 20639 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) S. Mem. Gardens | | 20c. Location - City or Town, State 8/7/99 Dunkirk, MD |
| | 21. Signature of Funeral Service Licenses  | | 22. Name and Address of Facility Raymond Funeral Home, P.A. P.O. Box 121, Dunkirk, MD 20754 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Renal Failure</p> <p>b. colon cancer</p> <p>c. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred | | | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  29c. License number 047610 29d. Date signed (Month, Day, Year) August 4 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. David Tardio, M.D. Prince Frederick, MD 20678 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 05 1999 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 26834**
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--------------------------------|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Stephanie Dawn Eades | | | | 2. Date of Death Month May Day 22 Year 1999 | | 3. Time of Death 9:40 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | |
| Funeral Director | 5. Social Security Number 235 15 4705 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 20 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 10, 1978 | 9. Birthplace (State or Foreign Country) W. Va. |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 1380 Marshall St. | | | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) handicapped | | 16b. Kind of Business/Industry none | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Roger C. Haynes | | | | 18. Mother's Name (First, Middle, Maiden Surname) Linda F. Haynes | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Linda F. Haynes Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Manda Dr. Middletown Md. 21769 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Reformed Cemetery | | Date 5/25/99 | | 20c. Location - City or Town, State Middletown, Md. | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Donald B. Thompson Funeral Home Middletown, MD. 21769 | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | Approximate Interval Between Onset and Death | |
| | Immediate Cause (Final disease or condition resulting in death) Aspiration of Mucous Plug into Lungs | | | | | | 5 minutes | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Chronic Pulmonary insufficiency | | | | | | 3 years | |
| | Recurrent Pneumonias and aspiration | | | | | | 12 years | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Advanced Kyphoscoliosis with Severe chest deformity | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier Robert Biroll MD Personal Physician | | | | 29c. License number DO4-359 | | 29d. Date signed (Month, Day, Year) May 24 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Biroll MD 1459 Potomac Ave. Hagerstown, Md 21742 | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 27 1999 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

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 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Do NOT
copy until
name has
been corrected

^{2/27/75}
Thanks - A. Arice

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26835

Certificate of Death

Reg. No.

| | | | | | |
|---|--|---|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HELEN FREELAND | | 2. Date of Death Month Day Year July 27 1999 | | 3. Time of Death 7:30 p.m. |
| | 4a. Facility Name (If not institution, give street and number) Hemitage at St. Johns Creek | | 4b. City, Town, or Location of Death Solomons | | 4c. County of Death Calvert |
| Funeral Director | 5. Social Security Number 453 26 4271 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 102 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth Month Day Year May 15, 1897 | | 9. Birthplace (State or Foreign Country) California | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | | 10b. County Calvert | | 10c. City, Town or Location Solomons | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 13325 Dowell Road | | | 10f. Zip Code 20688 | | 10g. Citizen of What Country? United States |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: white | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Secretary Dept. Army | | 16b. Kind of Business/Industry | |
| 17. Father's Name (First, Middle, Last) Lewis McKisick | | | 18. Mother's Name (First, Middle, Maiden Surname) Agnes D. Dormin | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert Freeland- son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44059 Fieldstone Way California Md. 20619-209 | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Funeral Service | | 20c. Location - City or Town, State Alexandria Virginia | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 2067 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure | | | | | |
| Due to (or as a consequence of): | | | | | |
| b. Due to (or as a consequence of): | | | | | |
| c. Due to (or as a consequence of): | | | | | |
| d. Due to (or as a consequence of): | | | | | |
| 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Approximate Interval Between Onset and Death 6 months | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number D25156 | | 29d. Date signed (Month, Day, Year) 7/28/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Bennett M.D., 11845 Truman Rd. Lusby, Md. 20657 | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1999 | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

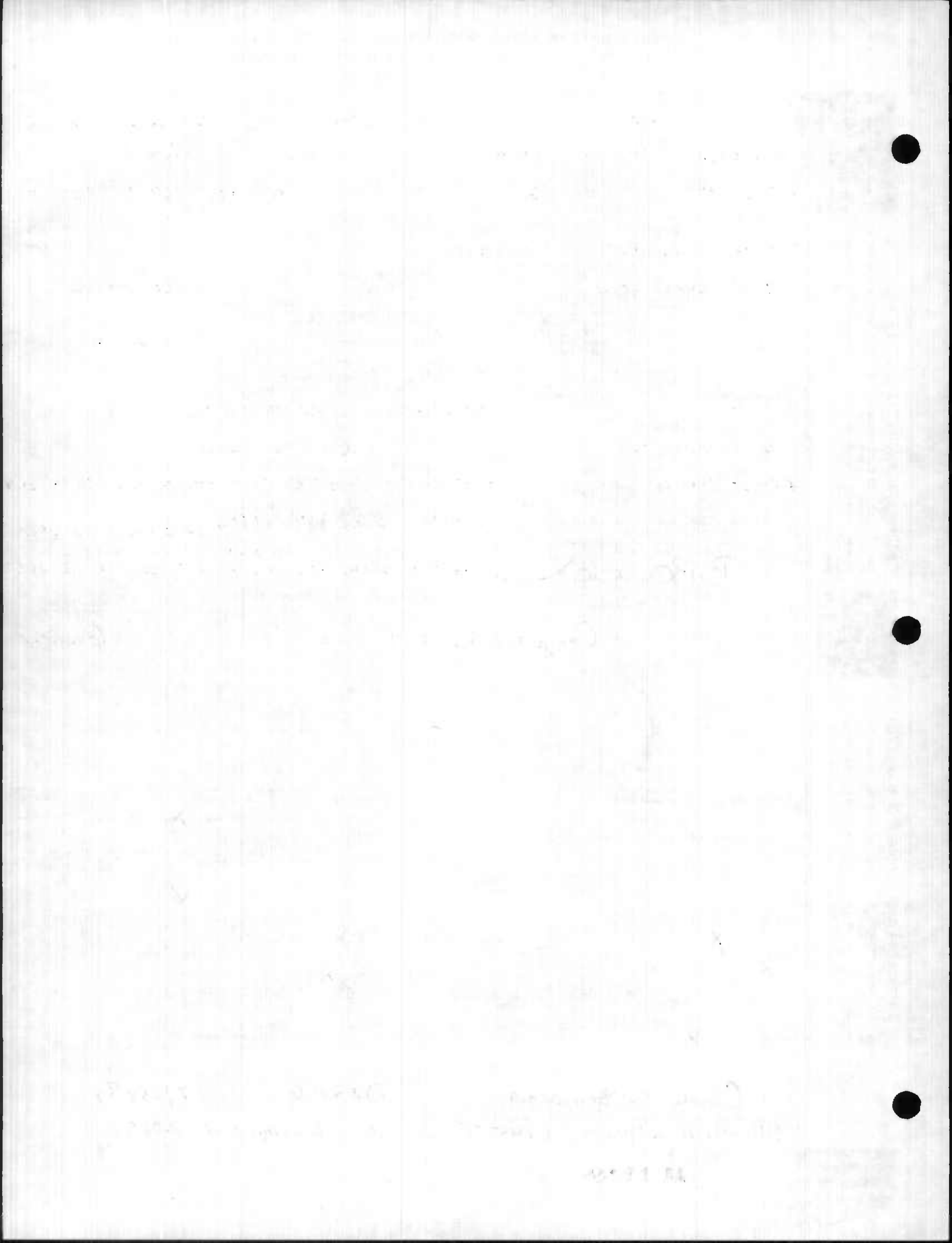
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26836

| | | | | | | | | | |
|---|---|---|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Anna Mae Folliard | | | | 2. Date of Death Month Day Year July 27, 1999 | | 3. Time of Death 10:00 AM | | |
| | 4a. Facility Name (If not institution, give street and number) 9226 Goldenrod Lane | | | | 4b. City, Town, or Location of Death Upper Marlboro | | 4c. County of Death Prince George's | | |
| Funeral Director | 5. Social Security Number 579-34-0984 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 70 Yrs. | | 8. Date of Birth (Month, Day, Year) April 13, 1929 | | |
| | 9. Birthplace (State or Foreign Country) Washington DC | | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Upper Marlboro | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 9226 Goldenrod Lane | | 10f. Zip Code 20772 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer / Payroll | | 16b. Kind of Business/Industry U.S. Navy | | | | | |
| 17. Father's Name (First, Middle, Last) Andrew C. Coleman | | | | 18. Mother's Name (First, Middle, Maiden Surname) Florence St. John | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Frank Coleman (Brother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9226 Goldenrod Lane, Upper Marlboro, Maryland 20772 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery | | | | 20c. Location - City or Town, State Brentwood, Maryland | |
| 21. Signature of Funeral Service Licensee Kelli R. Potter | | | | 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebral Metastases Due to (or as a consequence of): b. Metastatic Carcinoma of Lung Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Lung Disease | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Mati Koul M.D. | | 29c. License number MD D24020 | | 29d. Date signed (Month, Day, Year) 7/27/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mati Koul M.D. 3710 Rivera Street #2C Temple Hills, Maryland 20748 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 29 1999 | | 32. Registrar's Signature Bernice B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26837

| | | | | | | | | |
|---|--|--|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HARRIET BARKLEY GRANT | | | | 2. Date of Death Month Aug , Day 8 , Year 1999 | | 3. Time of Death 5:00 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) 6375 Thamer Rd. | | | | 4b. City, Town, or Location of Death Neavitt | | 4c. County of Death Talbot | |
| Funeral Director | 5. Social Security Number 221-07-7467 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 23, 1906 | |
| | 9. Birthplace (State or Foreign Country) New York | | 10a. State Maryland | | 10b. County Talbot | | 10c. City, Town or Location Neavitt | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 6375 Thamer Rd. | | 10f. Zip Code 21652 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Guide | | 16b. Kind of Business/Industry Dupont Museum | | | |
| | 17. Father's Name (First, Middle, Last) James A. Barkley | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marie Pietre | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Edward A. Grant Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1031 Dempster Rd. Shrub Oak, New York 10588 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Capitol Crematory Aug. 9, 1999 | | 20c. Location - City or Town, State Dover, Delaware | | | |
| | 21. Signature of Funeral Service Licensee <i>Harrison E. Leonard</i> | | | | 22. Name and Address of Facility Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HYPERTENSIVE CARDIAC DISEASE 4 YRS b. HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. d. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier <i>J. von</i> | | | | 29c. License number 053597 | | 29d. Date signed (Month, Day, Year) 8/9/99 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John L. von Klar M.D. 800 S. Talbot St. St. Michaels, Maryland 21663 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 10 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26038

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BETTY RUTH GERARDI

2. Date of Death
Month Day Year
August 11, 19993. Time of Death
2:45p.m.

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

441-26-4291

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

FEB. 6, 1920

9. Birthplace (State or Foreign Country)

OKLAHOMA

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

26358 ARCADIA SHORES LANE

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

ACCOUNTANT

16b. Kind of Business/Industry

ACCOUNTING FIRM

17. Father's Name (First, Middle, Last)

EVERETT R. WILES

18. Mother's Name (First, Middle, Maiden Surname)

MAUDE A. KEMLER

19a. Informant's Name/Relationship (Type, Print)

VINCENT GERARDI/ HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26358 ARCADIA SHORES LANE, EASTON, MD 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MARYLAND VETERAN CEMETERY 8-16-99 HURLOCK, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A.

200 S. HARRISON ST., EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. CVA

4 mos

Due to (or as a consequence of):

b. Complication of angiogram

4 mos

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Atherosclerotic Vascular Disease

>15 yrs

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Tobacco abuse

HTN

Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD A. BURGOYNE, M.D., 607 DUTCHMAN'S LANE, EASTON, MD 21601

31. Date filed (Month, Day, Year)

AUG 13 1999

32. Registrar's Signature

Richard A. Burgoyne

State
Registrar

Betty Gerardi
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26839

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John L. Gordon

2. Date of Death

Month Day Year
AUGUST 15, 1999

3. Time of Death

10:53AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

St. Marys Hospital

4b. City, Town, or Location of Death

Leonardtwn

4c. County of Death

St. Marys

5. Social Security Number

154-05-5040

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

December 23, 19

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Marys

10c. City, Town or Location

Dameron

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

173111 Three Notch Rd

10f. Zip Code

20628

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Dispatcher

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Zachariah

Gordon

18. Mother's Name (First, Middle, Maiden Surname)

Isabelle

Conway

19a. Informant's Name/Relationship (Type, Print)

Mary Rothwell/ Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22780 Longmore St. Leonardtown MD 20650

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Peters Claver Cath. Ch. 8/21/99 Inigoes MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Adams Funeral Home P.A. Aquasco Md 20608

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Cardio respiratory failure

few min.

Due to (or as a consequence of):

b. Profound dementia

few months

Due to (or as a consequence of):

c. DM (Diabetes Mellitus)

long time

Due to (or as a consequence of):

d. Htcr (hypertension)

long time

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Shah

29c. License number

D 47066

29d. Date signed (Month, Day, Year)

8-17-99

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DR. AVANI D. SHAH

HOLLYWOOD, MD. 20636

State
Registrar

31. Date filed (Month, Day, Year)

AUG 17 1999

32. Registrar's Signature

B. Spinks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

JOHN LOUIS GORDON

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26840

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|--|---|---|--|--|--|--|---|----|-----|----------------------------------|-------|----|------------------------|----------------------------------|-------|----|--|----------------------------------|--|----|--|----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Dorothy Florence Gary | | | | | | 2. Date of Death Month Day Year August 6, 1999 | | 3. Time of Death 4:15 P.M. | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 1608 Arundel Road | | | | | | 4b. City, Town, or Location of Death Edgewater | | 4c. County of Death Anne Arundel | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 383-12-8586 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) May 20, 1922 | | 9. Birthplace (State or Foreign Country) Oklahoma | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Edgewater | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number 1608 Arundel Road | | | | 10f. Zip Code 21037 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1944-45 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bridal Consultant | | | 16b. Kind of Business/Industry Department Store | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) John Bailey Coats | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Nellie Staley | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Joy A. Lautar/ Daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1608 Arundel Road Edgewater, MD 21037 | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Poplar Springs Ch. Cem. | | Date 8-9-99 | | 20c. Location - City or Town, State Newton, Mississippi | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 | | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>CHF</td> <td>Due to (or as a consequence of):</td> <td>4 yrs</td> </tr> <tr> <td>b.</td> <td>Valvular heart disease</td> <td>Due to (or as a consequence of):</td> <td>4 yrs</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | CHF | Due to (or as a consequence of): | 4 yrs | b. | Valvular heart disease | Due to (or as a consequence of): | 4 yrs | c. | | Due to (or as a consequence of): | | d. | | Due to (or as a consequence of): | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | CHF | Due to (or as a consequence of): | 4 yrs | | | | | | | | | | | | | | | | | | | | | | |
| | b. | Valvular heart disease | Due to (or as a consequence of): | 4 yrs | | | | | | | | | | | | | | | | | | | | | | |
| | c. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | |
| | d. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier John Jackson MD | | | | 29c. License number 730718 | | 29d. Date signed (Month, Day, Year) 8-9-99 | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Jackson, 2003 National Hwy, Annapolis, MD 21401 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

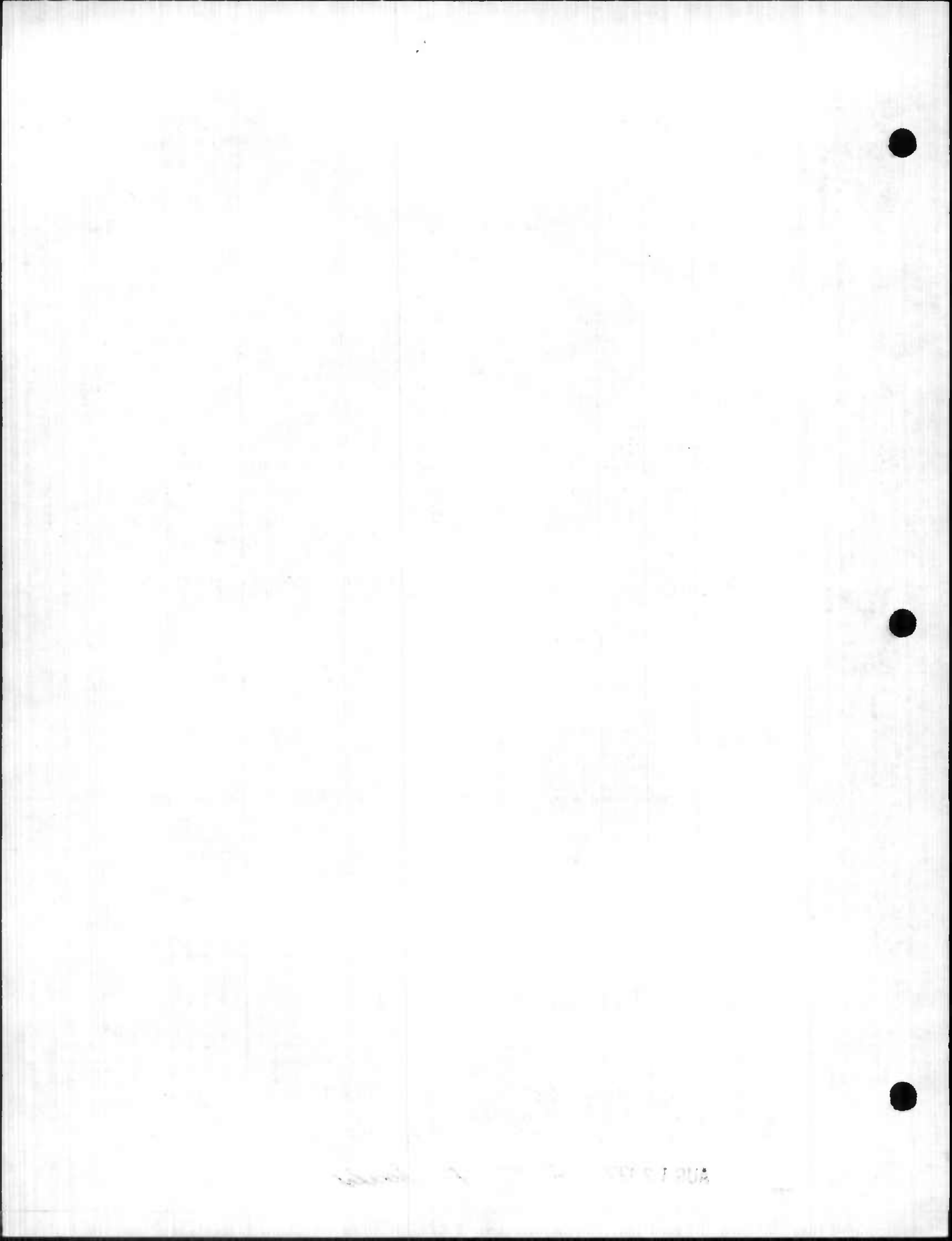
To Be Completed by Funeral Director

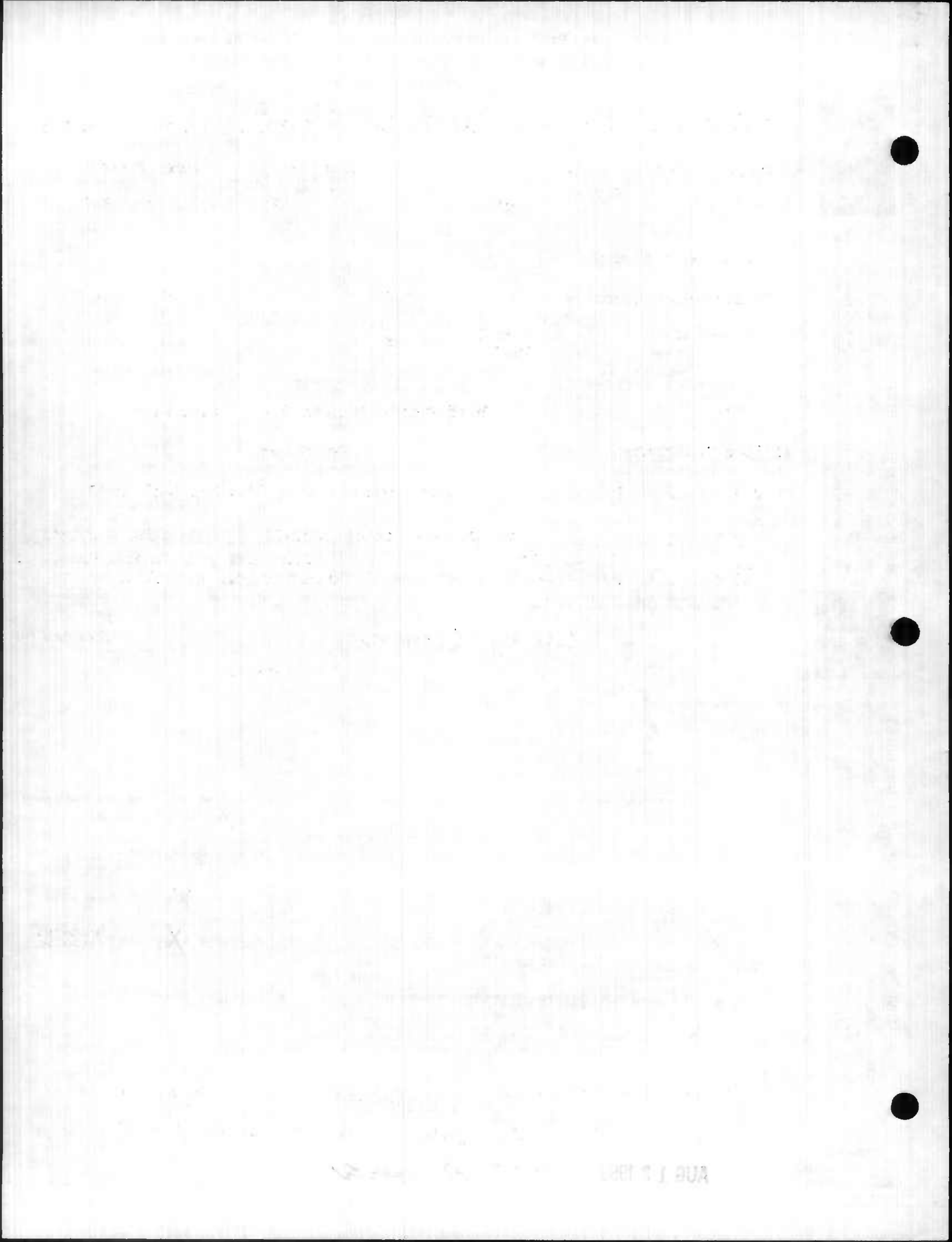
To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 16 Rev 6/95

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26842

| | | | | | | | | | |
|--|--|--|--|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILLIAM JOHN GLUCKERT, JR. | | | | 2. Date of Death Month Day Year AUGUST 11, 1999 | | 3. Time of Death 7:40 PM | | |
| | 4a. Facility Name (If not institution, give street and number) WILLIAM HILL MANOR, 25 Lynnbrook Terrace | | | | 4b. City, Town, or Location of Death EASTON | | 4c. County of Death TALBOT | | |
| Funeral Director | 5. Social Security Number 120-18-8010 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 94 Yrs. | | 8. Date of Birth (Month, Day, Year) SEPT. 6, 1904 | | |
| | 9. Birthplace (State or Foreign Country) NEW YORK | | 10a. State MD | | 10b. County TALBOT | | 10c. City, Town or Location EASTON | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 25 LYNNBROOK TERRACE | | 10f. Zip Code 21601 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PURCHASING AGENT | | 16b. Kind of Business/Industry PETROLEUM | | 16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PURCHASING AGENT | | | |
| 17. Father's Name (First, Middle, Last) WILLIAM J. GLUCKERT | | | | 18. Mother's Name (First, Middle, Maiden Surname) PAULINE BLANK | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MARGARET M. GLUCKERT / WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 LYNNBROOK TERRACE, EASTON, MD 21601 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN MEMORIAL PARK | | 20c. Location - City or Town, State EASTON, MD 21601 | | 20d. Date 8-18-99 | | | |
| 21. Signature of Funeral Service Licensee Joseph M. Ostrowski | | | | 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CVA Due to (or as a consequence of): ATHEROSCLEROSIS HTN Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 4 DAYS 20 YEARS 30 YEARS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Richard A. Burgoyne | | 29c. License number D42816 | | 29d. Date signed (Month, Day, Year) 8/12/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RICHARD A. BURGOYNE, M.D., 607 DUTCHMAN'S LANE, EASTON, MD 21601 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 13 1999 | | 32. Registrar's Signature P. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26843

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES

EDWARD

GROSS

2. Date of Death

Month Day Year

July 19

3. Time of Death

11:45

4a. Facility Name (If not institution, give street and number)

Univ. of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

214-32-9560

6. Sex

103 M 20 F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

July 17, 1937

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Lusby

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

451 Sollers Wharf Road

10f. Zip Code

20657

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married

30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

10 Yes 20 No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Harry

Gross

18. Mother's Name (First, Middle, Maiden Surname)

Matilda

Johnson

19a. Informant's Name/Relationship (Type, Print)

Eva Gross/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

451 Sollers Wharf Road Lusby, MD 20657

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State

40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ernestine Jones Cemetery

Date

7/24/99

20c. Location - City or Town, State

Chesapeake Beach, MD

21. Signature of Funeral Service Licensee

Blacks G. Sewell

22. Name and Address of Facility

Sewell Funeral Home

1451 Dares Beach Road Prince Frederick, MD 20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

Stroke

Due to (or as a consequence of):

Atrial Fibrillation

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Hypertension

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy
performed?

10 Yes 20 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

10 Yes 20 No

25. Was case referred to medical
examiner?

10 Yes 20 No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

26. Place of Death (Check only one)

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural

50 Pending

20 Accident

investigation

30 Suicide

60 Could not be

40 Homicide

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

10 Certifying Physician:

20 Medical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Stephen J. Martino MD

29c. License number

A04176435

29d. Date signed (Month, Day, Year)

7/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen J. Martino MD

UMMS, Baltimore MD

State
Registrar

31. Date filed (Month, Day, Year)

JUL 22 1999

32. Registrar's Signature

G. Sparks

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

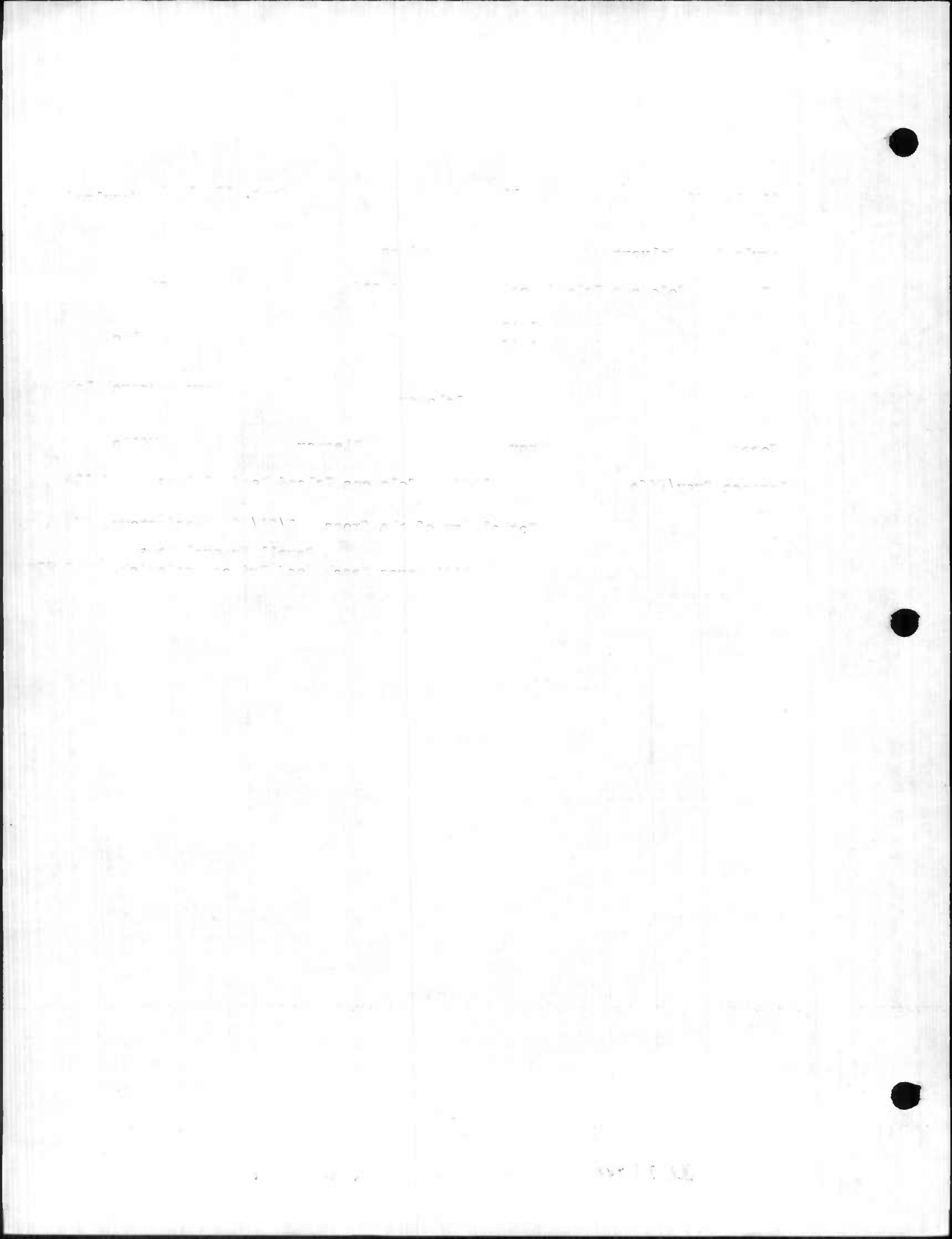
99 26844

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Julius Gray</i> | | | | 2. Date of Death Month <i>July</i> Day <i>27</i> Year <i>1999</i> | | | | 3. Time of Death <i>22:55</i> | | |
| | 4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical System</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | | | 4c. County of Death <i>Baltimore City</i> | | |
| Funeral Director | 5. Social Security Number <i>213-22-0560</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>73</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>Sept. 17, 1925</i> | | 9. Birthplace (State or Foreign Country) <i>Maryland</i> | | |
| | Usual Residence of Decedent | | | | 10a. State <i>Maryland</i> | | | | 10b. County <i>Calvert</i> | | |
| 10c. City, Town or Location <i>Owings</i> | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 10e. Street and Number <i>7860 Solomons Island Road</i> | | | | 10f. Zip Code <i>20736</i> | | | | 10g. Citizen of What Country? <i>USA</i> | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>1943-</i> If Yes, Give Year or Dates: <i>1946</i> | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | |
| 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Laborer</i> | | | |
| 16b. Kind of Business/Industry <i>Navy Research Lab</i> | | | | 17. Father's Name (First, Middle, Last) <i>Joseph Gray</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Eleanor Wills</i> | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Florence Gray/Wife</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7860 Solomons Island Road Owings, MD 20736</i> | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Bethel Way of the Cross</i> | | | | 20c. Location - City or Town, State <i>Huntingtown, MD</i> | | | |
| 21. Signature of Funeral Service Licensee <i>Shady G. Sewell</i> | | | | 22. Name and Address of Facility <i>Sewell Funeral Home</i> <i>1451 Dares Beach Road Prince Frederick, MD 20678</i> | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cerebral herniation</i> Due to (or as a consequence of): b. <i>Intracerebral hemorrhage</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury <i>M</i> | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> MD | | | | 29c. License number <i>P12446</i> | | | | 29d. Date signed (Month, Day, Year) <i>July 28, 1999</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>T. Matthews, MD 22 South Green St Baltimore, MD 21210</i> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>JUL 30 1999</i> | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

7+1



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State of Maryland / Department of Health and Mental Hygiene 99 26845

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Margaret Mary Garbinsky | | | | 2. Date of Death Month 7 Day 30 Year 99 | | 3. Time of Death 9:45 pm | |
| | 4e. Facility Name (If not institution, give street and number) Manor Care Health Services | | | | 4b. City, Town, or Location of Death Largo | | 4c. County of Death Prince Georges | |
| Funeral Director | 5. Social Security Number 578-12-4395 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) 7/20/19 | |
| | 9. Birthplace (State or Foreign Country) Wash., D.C. | | 10a. State MD | | 10b. County Prince Georges | | 10c. City, Town or Location Upper Marlboro | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 14608 Crescent Drive | | 10f. Zip Code 20772 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Meat Packer | | 16b. Kind of Business/Industry Grocery Store | | | |
| | 17. Father's Name (First, Middle, Last) Perry Carman | | 18. Mother's Name (First, Middle, Maiden Surname) Josephine Mc Cusker | | 19e. Informant's Name/Relationship (Type, Print) Millard Garginsky/spouse | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14608 Crescent Dr. Upper Marlboro MD 20772 | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans | | Date 8/4/99 | | 20c. Location - City or Town, State Cheltenham, MD | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Raymond Funeral Home, P.A. P.O. Box 121, Dunkirk, MD 20754 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Atherosclerosis</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death years. | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D20108 | | 29d. Date signed (Month, Day, Year) 8/2/99 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 14300 Gallant Fox #222 Bowie MD 20715 | | 31. Date filed (Month, Day, Year) AUG 01 1999 | | 32. Registrar's Signature | | 33. Registrar's Name Rakesh Anand | |
| | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

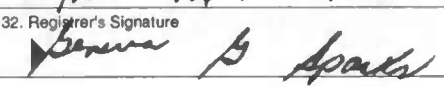
5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26846

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HESTER JANE GAHAN | | | | 2. Date of Death Month August Day 4 Year 1999 | | 3. Time of Death 0132 | |
| | 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | |
| Funeral Director | 5. Social Security Number 212-20-5014 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 23, 1923 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Wicomico | | 10c. City, Town or Location Salisbury | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1110 Healthway Dr. | | | | 10f. Zip Code 21804 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) - | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auditor | | | 16b. Kind of Business/Industry State of Maryland | |
| 17. Father's Name (First, Middle, Last) William Garfield Hudgins | | | | 18. Mother's Name (First, Middle, Maiden Surname) Myrtle Cullison | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Gibson Gahan/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3010 White Oak Lane, Charlottesville, VA 22911 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory | | Date 8/5/99 | | 20c. Location - City or Town, State Salisbury, MD | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Due to (or as a consequence of): COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2 day | | | | | | | | Approximate Interval Between Onset and Death 2 day |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D29105 | | 29d. Date signed (Month, Day, Year) 8/4/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTIAN ALDOLSTON, M.D. 106 MILFORD ST. SALISBURY, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 06 1999 | | 32. Registrar's Signature  | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

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1000 0 0 000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26847

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JUDITH

AMANDA

GODWIN

2. Date of Death

Month
08Day
08Year
99

3. Time of Death

0634

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

426-17-0201

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

33 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
06-03-66

9. Birthplace (State or Foreign Country)

Mississippi

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7917 Boylston Bend

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4or 5+)
218a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Licensed Practical Nurse

16b. Kind of Business/Industry

Medicine

17. Father's Name (First, Middle, Last)

Hubert Franklin Pilgrim

18. Mother's Name (First, Middle, Maiden Surname)

Judith Ann Ewing

19a. Informant's Name/Relationship (Type, Print)

Karen P. Cannon/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30134 Oak Haven Ave., Delmar, MD 21875

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Salisbury Crematory

Date

8/9/99

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

David M. Thompson

MD 1051

22. Name and Address of Facility

Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 2180423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. GUNSHOT TO HEAD

Due to (or as a consequence of):

b. SELF INFLICTED

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☒ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)

08-07-99

28b. Time of
Injury

1155

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

SELF-INFLICTED

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

7917 BOYLSTONE BEND

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

SALISBURYMD

29a. Certifier
(Check only
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

John G. Bulkeley

D.M.E.

29c. License number

D0003599

29d. Date signed (Month, Day, Year)

08-08-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOHN T. BULKELEY, M.D., 106 MILFORD ST, SUITE 201, SALISBURY MD 21801

31. Date filed (Month, Day, Year)

AUG 09 1999

32. Registrar's Signature

Bulkeley

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5

State
Registrar

8/3/99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend #17

State of Maryland / Department of Health and Mental Hygiene

99 26848

James Pinkney Gaddis CCHD kds

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ADAM Marr GADDIS | | | | 2. Date of Death Month Day Year JULY 26 1999 | | 3. Time of Death 9:10PM | |
| | 4a. Facility Name (If not institution, give street and number) 2610 RITCHIE MARLBORO ROAD | | | | 4b. City, Town, or Location of Death UPPER MARLBORO | | 4c. County of Death PRINCE GEORGE'S | |
| Funeral Director | 5. Social Security Number 217-44-0441 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb 10, 1911 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County P.G. | | 10c. City, Town or Location Upper Marlboro | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 2610 Ritchie Marlboro Road | | 10f. Zip Code 20774 | |
| | 10g. Citizen of What Country? United States | | | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Research Chemist/ Farmer | | | | 16b. Kind of Business/Industry Dept of Agriculture | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) James Pinkney Gaddis | | | | 18. Mother's Name (First, Middle, Maiden Surname) Edith Marr | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Anna Gaddis Rauch (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2610 Ritchie Marlboro Road, Upper Marlboro, MD 20774 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery July 30, 1999 Suitland, Maryland | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ischemic Myocardopathy | | | | Approximate Interval Between Onset and Death Months | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Arteriosclerotic Cardiovascular Disease | | | | Due to (or as a consequence of): Years | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | Prostate Adenocarcinoma | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | Esophagogastric Stricture | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | | |
| | 28b. Time of Injury M | | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier Gerald P. Sterner M.D. | | | | 29c. License number D17245 | | | |
| | 29d. Date signed (Month, Day, Year) JULY 27, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GERALD P. STERNER, M.D. 19 CHESAPEAKE BEACH RD. OWINGS, MARYLAND 20736 | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year) JUL 29 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | |
| | 33. Registrar's Name B. Sparks | | | | 34. Registrar's Title Registrar | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

15

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26849

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT A. HURFORD

2. Date of Death
Month Day Year
August 6 19993. Time of Death
2330

4a. Facility Name (If not institution, give street and number)

Easton Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

178-20-4583

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

APR. 6, 1927

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

ST. MICHAELS

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

9522 MARTINGHAM CIRCLE

10f. Zip Code

21663

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

EXECUTIVE

16b. Kind of Business/Industry

COMMUNICATION

17. Father's Name (First, Middle, Last)

CHARLES HENRY HURFORD

18. Mother's Name (First, Middle, Maiden Surname)

LILY JONES

19a. Informant's Name/Relationship (Type, Print)

BETTY T. HURFORD/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9522 MARTINGHAM CIRCLE, ST. MICHAELS, MD 21663

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATION CTR 9-9-99

Date

20c. Location - City or Town, State

STEVENSVILLE, MD

21. Signature of Funeral Service Licensee

M. E. Newnam III C.F.S.P.

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 S. HARRISON ST., EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Cerebral Emboli

Due to (or as a consequence of):

b. Endo carditis

Due to (or as a consequence of):

c. Ulcerative Colitis

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

9 days

unk

one year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. T. Forlifer MD

29c. License number

D36919

29d. Date signed (Month, Day, Year)

8-7-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUSAN T. FORLIFER, M.D., 505 DUTCHMAN'S LANE, EASTON, MD 21601

31. Date filed (Month, Day, Year)

AUG 9 1999

32. Registrar's Signature

B. Sparks

State
RegistrarRobert Hurford
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

W. H. 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26850

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY GINGER HAMILTON

2. Date of Death
Month Day Year

AUGUST 14 1999

3. Time of Death

1932

4a. Facility Name (If not Institution, give street and number)

UNION HOSPITAL

4b. City, Town, or Location of Death

ELKTON

4c. County of Death

CECIL

Funeral
Director

5. Social Security Number

217-46-1355

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

AUG 27, 1946

9. Birthplace (State or Foreign Country)

ELKTON MD

Usual Residence of Decedent

10a. State

MD.

10b. County

CECIL

10c. City, Town or Location

ELKTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

120 HUNTSMAN DRIVE

10f. Zip Code

21921

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

DIETARY AID

16b. Kind of Business/Industry

DIETARY HOSPITAL

17. Father's Name (First, Middle, Last)

IRVING S. HITCHCOCK

18. Mother's Name (First, Middle, Maiden Summa)

REBA GOODYEAR HITCHCOCK

19a. Informant's Name/Relationship (Type, Print)

Herbert J. HAMILTON SR. HUSBAND 120 HUNTSMAN DRIVE ELKTON MD 21921

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ELKTON CEMETERY 8/19/99 ELKTON MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Edward Wilson

22. Name and Address of Facility

Gee Funeral Home 259 E. MAIN ST.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

20 min.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jui Chih Han MD

29c. License number

D04823

29d. Date signed (Month, Day, Year)

8/15/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JUI CHIH HSU MD 223 West main st. Elkton MD 21921.

31. Date filed (Month, Day, Year)

AUG 16 1999

32. Registrar's Signature

P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26851

AMEND ITEM: #5 PER F.H. G775 9-7-99 WR.

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ray Grant Hastings | | | | 2. Date of Death Month August Day 15 Year 1999 | | 3. Time of Death 1:25 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 109 Annapolis View Road | | | | 4b. City, Town, or Location of Death Stevensville | | 4c. County of Death Queen Anne's | |
| Funeral Director | 5. Social Security Number 036-20-5291 136-20-5291 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 67 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 7, 1931 | |
| | 9. Birthplace (State or Foreign Country) Rhode Island | | 10a. State Maryland | | 10b. County Queen Anne's | | 10c. City, Town or Location Stevensville | |
| Usual Residence of Decedent | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number 109 Annapolis View Road | | | | 10f. Zip Code 21666 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1949-53 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant | | 16b. Kind of Business/Industry Federal Government | | |
| 17. Father's Name (First, Middle, Last) Herman Ray Hastings | | | | 18. Mother's Name (First, Middle, Maiden Surname) Flora Armstrong | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Annette M. Hastings/ Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Annapolis View Road Stevensville, MD 21666 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. Location - City or Town, State 8-17-99 Alexandria, Virginia | | 21. Signature of Funeral Service Licensee | | |
| 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Squamous Cell Cancer of head Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D32036 | | 29d. Date signed (Month, Day, Year) 8/16/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary J. Sprouse 2108 Piedmont Drive Chester, MD 21619 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 17 1999 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26852

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Daniel Patrick HASSETT | | | | 2. Date of Death Month Day Year July 19, 1999 | | 3. Time of Death 5:57 pm | |
| | 4a. Facility Name (If not institution, give street and number) 3245 Southern Pine Lane | | | | 4b. City, Town, or Location of Death Port Republic | | 4c. County of Death Calvert | |
| Funeral Director | 5. Social Security Number 214 76 9463 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 42 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept. 14, 1956 | | 9. Birthplace (State or Foreign Country) Wash., DC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Calvert | | 10c. City, Town or Location Port Republic | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 3245 Southern Pine Lane | | | | 10f. Zip Code 20676 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) proprietor | | | 16b. Kind of Business/Industry restaurant | |
| 17. Father's Name (First, Middle, Last) John James Hassett | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Perenich | | | | |
| 19a. Informant's Name/Relationship (Type, Print) John J. Hassett/father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16638 Alden Ave., Gaithersburg, MD 20877 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | Date 7-21-99 | | 20c. Location - City or Town, State Alexandria, VA | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility 4405 Broomes Is. Road Rausch Funeral Home, Port Republic, MD 20676 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Cytoplasmic, Central Nervous system</i> b. <i>Acquired Immune Deficiency Syndrome</i> c. d. | | | | | | | | Approximate Interval Between Onset and Death 3 months ~8 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>David C. Barnes, MD</i> | | | 29c. License number D32469 | | 29d. Date signed (Month, Day, Year) July 20, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David C. Barnes, MD 64 Franklin St. Annapolis, MD 21401 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 21 1999 | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.
Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar
DHMH 16 Rev 6/95

99-4551-039

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

WILLIAM

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26853

HANKERSON III

| | | | | | | | | | | | |
|--|--|--------------------------------|---|---|--|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) William Hankerson III | | | | | | 2. Date of Death Month Day Year AUGUST 3, 1999 | | 3. Time of Death 10:15A.M. | | |
| | 4a. Facility Name (If not institution, give street and number) 31109 EDEN ALLEN ROAD | | | | | | 4b. City, Town, or Location of Death EDEN | | 4c. County of Death SOMERSET | | |
| Funeral Director | 5. Social Security Number 212-92-2095 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 28 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov 04, 1970 | | 9. Birthplace (State or Foreign Country) MD | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Somerset | | 10c. City, Town or Location Eden | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 31109 Eden Allen Road | | | | 10f. Zip Code 21822 | | | | 10g. Citizen of What Country? U.S. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | | 16b. Kind of Business/Industry Poultry | | | |
| 17. Father's Name (First, Middle, Last) William Hankerson, Jr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Letha Moore | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Letha Hankerson/mother | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31996 Flower Hill Church Rd., Eden, MD 21822 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Flower Hill Church Cem | | Date 8/7/99 | | 20c. Location - City or Town, State Eden, Maryland | | | |
| 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Contact Shotgun Wound of Chest Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated event resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) DRIVEWAY | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) 8/3/99 | | 28b. Time of Injury 910 A M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | 28d. Describe how injury occurred self inflicted shotgun wound | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 31109 Eden-Allen Road Somerset Co. Md | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 4, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, Jr. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 05 1999 | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

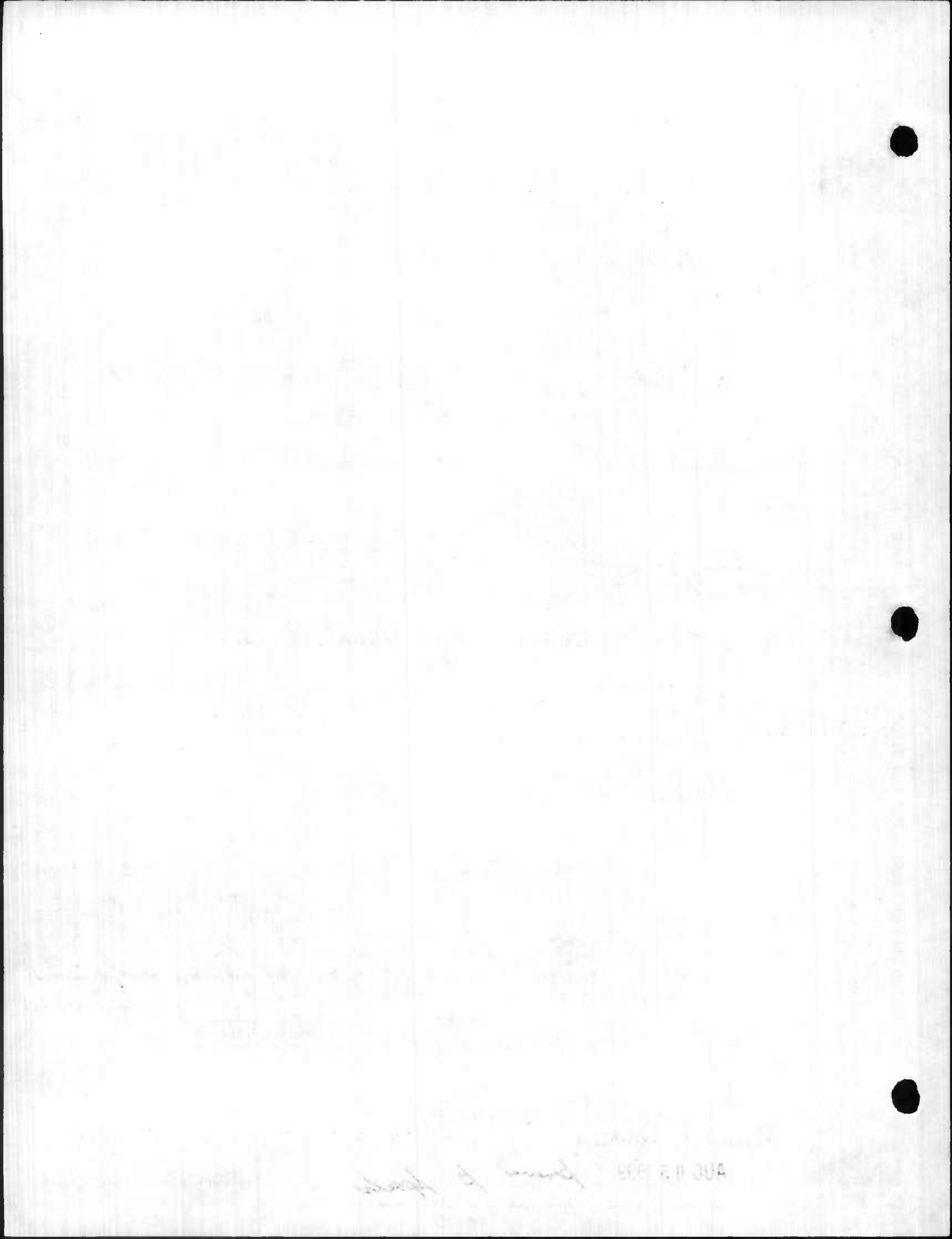
Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26854

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KATHALEEN HASTINGS

2. Date of Death
Month Day Year

8

10

99

3. Time of Death

1125

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

214-10-9524

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

8. Date of Birth
(Month, Day, Year)

11-03-08

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

217 N. Park Drive

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Sales lady

16b. Kind of Business/Industry

Clothing

17. Father's Name (First, Middle, Last)

William R. Parrott

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Woolford

19a. Informant's Name/Relationship (Type, Print)

Kay Ellen Hastings, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

217 N. Park Dr. Salisbury, Md. 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parsons Cemetery

Date

8-12-99

20c. Location - City or Town, State

Salisbury, Md.

21. Signature of Funeral Service Licensee

William M. Short

22. Name and Address of Facility

Short Funeral Home, Inc.

13 E. Grove St. Delmar, De. 19940

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ OOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John T. Bulkeley DME

29c. License number

D0003599

29d. Date signed (Month, Day, Year)

8-11-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN T. BULKELEY, M.D. 106 MILFORD STREET #201 SALISBURY, MD. 21804

31. Date filed (Month, Day, Year)

AUG 13 1999

32. Registrar's Signature

Beverly S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26855

| | | | | | | | | |
|---|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Timothy Edwin Hay | | | | 2. Date of Death Month Day Year AUGUST 2, 1999 | | 3. Time of Death 1720 PM | |
| | 4a. Facility Name (If not institution, give street and number) ROUTE 260 1/4 MILE EAST OF ROUTE 778 | | | | 4b. City, Town, or Location of Death OWINGS | | 4c. County of Death CALVERT | |
| Funeral Director | 5. Social Security Number 219 17 0969 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 25 Yrs. | | 8. Date of Birth (Month, Day, Year) May 23, 1974 | |
| | 9. Birthplace (State or Foreign Country) Wash., DC | | 10a. State MD | | 10b. County Calvert | | 10c. City, Town or Location Huntingtown | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 721 Bowie Shop Road | | 10f. Zip Code 20639 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) student | | 16b. Kind of Business/Industry college | | | | |
| 17. Father's Name (First, Middle, Last) Richard Isaac Hay | | | | 18. Mother's Name (First, Middle, Maiden Summa) Carolyn Rose Potter | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Richard I. Hay (father) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 927, Huntingtown, MD 20639 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Miranda Cemetery | | Date 8-6-99 | | 20c. Location - City or Town, State Huntingtown, MD | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE INJURIES Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | |
| Approximate Interval Between Onset and Death | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 08/02/99 | | 28b. Time of Injury 1715 PM | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred DRIVER IN AUTO ACCIDENT | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) ROUTE 260/ROUTE 778 | | | | |
| 29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 3, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ann Dixon M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 06 1999 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | |
|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last) HORACE Philip HAYDEN | | 2. Date of Death Month March Day 15 Year 1999 | | 3. Time of Death 2:53p |
| 4a. Facility Name (If not institution, give street and number) THE Johns Hopkins Hospital | | 4b. City, Town, or Location of Death Baltimore, City | | 4c. County of Death Baltimore City |
| 5. Social Security Number 577-52-2098 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs/last birthday) 61 Yrs. | 8. Date of Birth (Month, Day, Year) Dec. 1, 1937 | 9. Birthplace (State or Foreign Country) Washington, DC |
| Usual Residence of Decedent | | | | |
| 10a. State MD | 10b. County Queen Anne's | 10c. City, Town or Location Chester | | 10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number 45H Queen Neva Court | | 10f. Zip Code 21619 | | 10g. Citizen of What Country? U.S.A. |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Physic Engineer | | 16b. Kind of Business/Industry Dept. of Navy | | |
| 17. Father's Name (First, Middle, Last) Unknown Hayden | | 18. Mother's Name (First, Middle, Maiden Surname) Bess Whiting | | |
| 19a. Informant's Name/Relationship (Type, Print) Ruth Anne Hayden | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45H Queen Neva Court | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center LLC | | 20c. Location - City or Town, State Stevensville, MD |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, PA 106 Shamrock Road, Chester, MD 21619 | | |
| 23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. OBLITERATIVE BRONCHIOLITIS Due to (or as a consequence of): b. Status post right single lung transplant Due to (or as a consequence of): c. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): d. | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | Approximate Interval Between Onset and Death 6 months 5 years 19 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) M | | 28b. Time of Injury 1 Yes <input type="checkbox"/> No |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| 29b. Signature and title of certifier  | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) MARCH 15, 1999 |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) NEIL C. EVANS, MD 600 N. Wolfe Street BALTIMORE, MD 21287 | | | | |
| 31. Date filed (Month, Day, Year) MAR 18 1999 | | 32. Registrar's Signature  | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

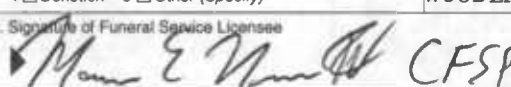
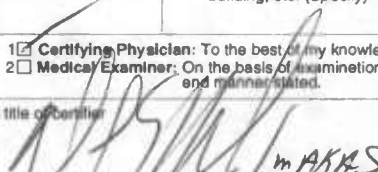
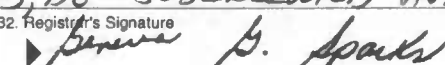
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26857

Certificate of Death

Reg. No.

| | | | | | | | |
|---|--|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Carl MACFARLANE Jones | | | | 2. Date of Death Month Day Year August 10 1999 | | 3. Time of Death 10:30AM |
| | 4a. Facility Name (If not institution, give street and number) Genesis ElderCare - The Pines | | | 4b. City, Town, or Location of Death Easton | | 4c. County of Death Talbot | |
| Funeral Director | 5. Social Security Number 228-09-0792 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 86 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JULY 10, 1913 | 9. Birthplace (State or Foreign Country) GEORGIA |
| | Usual Residence of Decedent | | | | | | |
| 10a. State MD | | 10b. County CAROLINE | | 10c. City, Town or Location PRESTON | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 21135 TANYARD ROAD | | | | 10f. Zip Code 21655 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1947 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INDUSTRIAL ENGINEER | | 16b. Kind of Business/Industry POSTAL SERVICE | |
| 17. Father's Name (First, Middle, Last) WILLIAM MACFARLANE JONES | | | | 18. Mother's Name (First, Middle, Maiden Surname) AMY ALLEN | | | |
| 19a. Informant's Name/Relationship (Type, Print) ALICE C. JONES/ WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21135 TANYARD ROAD, PRESTON, MD 21655 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN MEMORIAL PARK | | Date 8-13-99 | | 20c. Location - City or Town, State EASTON, MD 21601 | |
| 21. Signature of Funeral Service Licensee  CFSP | | | | 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. ASPIRATION PNEUMONIA Due to (or as a consequence of) DAYS b. CONGESTIVE HEART FAILURE Due to (or as a consequence of) YEARS c. THIRD DEGREE HEART BLOCK Due to (or as a consequence of) MONTHS d. RENAL FAILURE Due to (or as a consequence of) MONTHS | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of Certifier  MAKAS | | 29c. License number H48241 | | 29d. Date signed (Month, Day, Year) 8/10/99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DANIEL E. MAKAS, DO 508 IDLEWILD AVE EASTON, MD 21601 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | 32. Registrar's Signature  B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

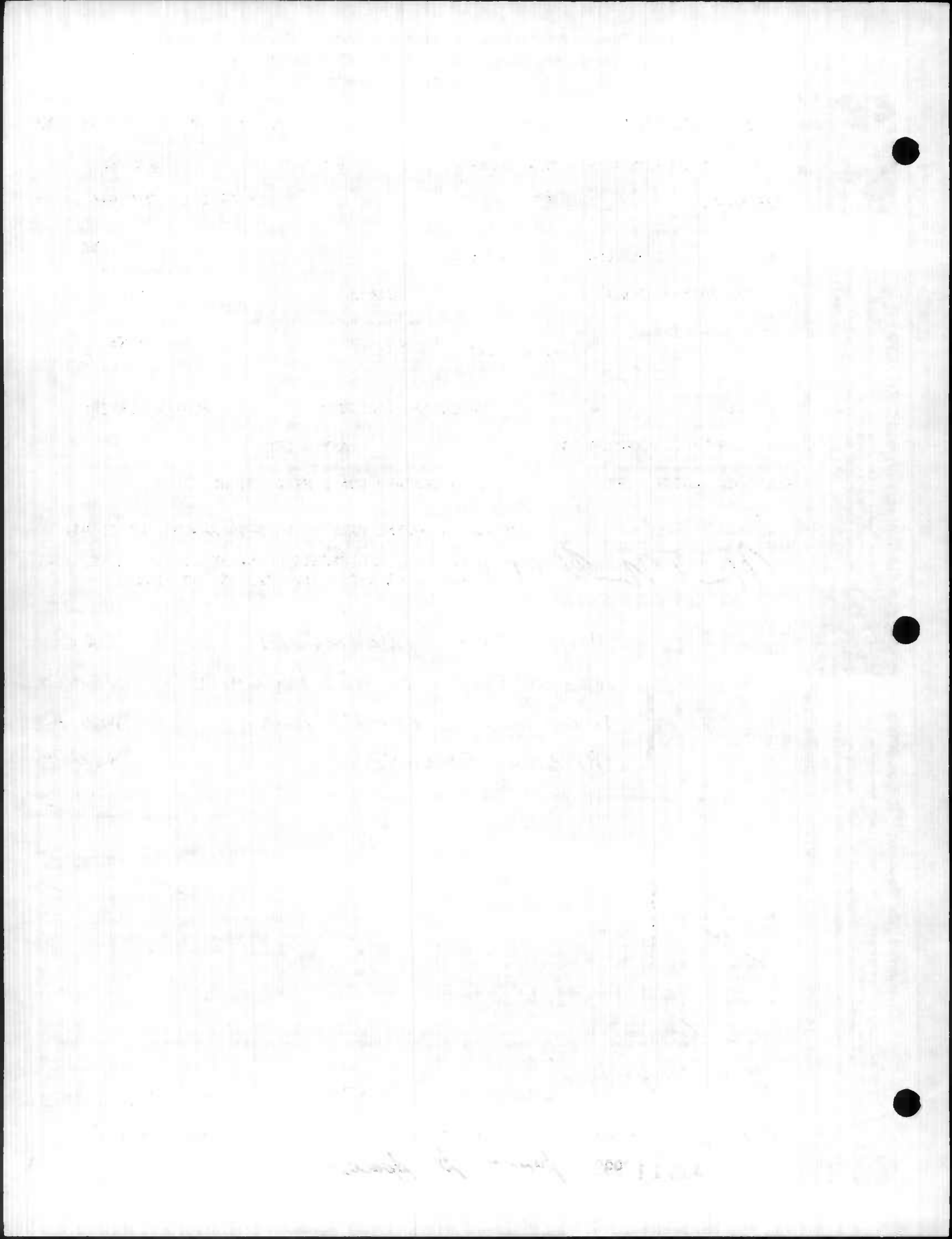
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26858

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|--|---------------------------------|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) PAULINE HARRISON JENKINS | | | | 2. Date of Death Month 08 Day 11 Year 99 | | 3. Time of Death 10:00AM | |
| | 4e. Facility Name (If not institution, give street and number) CAROLINE NURSING HOME, INC. | | | | 4b. City, Town, or Location of Death DENTON | | 4c. County of Death CAROLINE | |
| Funeral Director | 5. Social Security Number 218-34-7590 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 Yrs. | 8. Data of Birth (Month, Day, Year) MAY 16, 1907 | 9. Birthplace (State or Foreign Country) MARYLAND | | |
| | Usual Residence of Decedent | | | | | | | |
| 10e. State MD | | 10b. County TALBOT | | 10c. City, Town or Location TILGHMAN | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 21528 GIBSONTOWN ROAD | | | | 10f. Zip Code 21671 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SCHOOL TEACHER | | 16b. Kind of Business/Industry EDUCATION | | |
| 17. Father's Name (First, Middle, Last) JOHN B. HARRISON | | | | 18. Mother's Name (First, Middle, Maiden Surname) LOTTIE E. COVINGTON | | | | |
| 19a. Informant's Name/Relationship (Type, Print) DAVID L. McQUAY/ NEPHEW | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 207, TILGHMAN, MD 21671 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) SPRING HILL CEMETERY | | Data 8-16-99 | | 20c. Location - City or Town, State EASTON, MD 21601 | | |
| 21. Signature of Funeral Service Licensee <i>Man E. Newnam</i> CFSP | | | | 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Sepsis</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death days |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>dementia</u> | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29b. Signature and title of certifier <i>Wafik Zaki</i> MD | | | | 29c. License number MD D 47534 | | 29d. Date signed (Month, Day, Year) 8/11/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAFIK ZAKI, M.D., 920 MARKET ST., DENTON, MD 21629 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 13 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Sample 0, 1000, 1000, 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26859

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Maxine VanDyke Jamison

2. Date of Death

August 11, 1999

3. Time of Death

13:15

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

217-50-1186

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 28, 1906

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1022 Chesapeake Drive

10f. Zip Code

21078

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In her own home

17. Father's Name (First, Middle, Last)

Joseph Lee VanDyke

18. Mother's Name (First, Middle, Maiden Surname)

Anna Belle Blair

19a. Informant's Name/Relationship (Type, Print)

James VanDyke Jamison

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 4027, Pinehurst, North Carolina 28374

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford Memorial Gardens

Date

August 14,

20c. Location - City or Town, State

Aldino, Maryland

21. Signature of Funeral Service Licensee

Madelyn Mitchell Shank

22. Name and Address of Facility

Madelyn Mitchell Shank - Crouch Funeral Home
127 South Main Street, North East, Maryland 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- HTN

- CHF

- CAD

- CORONARY STENOSIS

- COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

T. Biondo MD.

29c. License number

S42800

29d. Date signed (Month, Day, Year)

8/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. Biondo 319 Union Ave., Havre de Grace, MD, 21078

31. Date filed (Month, Day, Year)

AUG 13 1999

32. Registrar's Signature

Brenda B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

WRC
99-4345-009
ALPHONSO N.
JOHNSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend 20b, So. Memorial Gardens Certificate of Death

Reg. No.

99 26860

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
2025.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | |
|---|--|--|---|---|--|--|--------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Alphonso Johnson | | | | 2. Date of Death Month Day Year JULY 23, 1999 | | 3. Time of Death 3:00 PM. | | |
| | 4a. Facility Name (If not institution, give street and number) RT. 2 AND 4 SOUTH AT SAWMILL RD. | | | | 4b. City, Town, or Location of Death Lusby | | 4c. County of Death Calvert | | |
| Funeral Director | 5. Social Security Number 215-88-3444 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 26 Yrs. | 8. Date of Birth (Month, Day, Year) Apr. 27, 1973 | 9. Birthplace (State or Foreign Country) Maryland | | | | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | 10b. County Calvert | | 10c. City, Town or Location Lusby | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10a. Street and Number 511 Bafford Road | | | | 10f. Zip Code 20657 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | 16b. Kind of Business/Industry Construction | | | |
| 17. Father's Name (First, Middle, Last) Alexander Johnson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sheila Gantt | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Sheila Johnson/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Bafford Road Lusby, MD 20657 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. John UMC Cemetery Southern Mem. Gardens | | 20c. Location - City or Town, State 7/30/99 Lusby, MD Dunkirk | | | | | |
| 21. Signature of Funeral Service Licensee ► <i>Glenn A. Swell</i> | | 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Multiple Injuries</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 7/23/99 | | 28b. Time of Injury 1500 P M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street | | 28d. Describe how injury occurred motorcycle accident | | | | | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) Calvert Co. Rd | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Rt 2 / 14 Sawmill Rd | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier ► <i>Dennis J. Chute</i> | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) JULY 24, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dennis Chute</i> 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 26 1999 | | | | 32. Registrar's Signature ► <i>B. Sparks</i> | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26861

| | | | | | | | | |
|---|---|--|--|---|--|---------------------------------|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ELWOOD HARVEY JACKSON | | | | 2. Date of Death Month August Day 7 Year 1999 | | 3. Time of Death 7:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) 305 Carey Avenue | | | | 4b. City, Town, or Location of Death Salisbury | | 4c. County of Death Wicomico | |
| Funeral Director | 5. Social Security Number 217-36-0797 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | 8. Date of Birth (Month, Day, Year) March 21, 1908 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Wicomico | | 10c. City, Town or Location Salisbury | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 305 Carey Ave. | | 10f. Zip Code 21804 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) - | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer | | | | 16b. Kind of Business/Industry Farming | | | |
| | 17. Father's Name (First, Middle, Last) Harvey A. Jackson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Julia A. Hay | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Ruth A. Thompson/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Carey Ave., Salisbury, MD 21804 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sudlersville Cemetery | | 20c. Location - City or Town, State 8/10/99 Sudlersville, MD | |
| | 21. Signature of Funeral Service Licensee <i>David H. Thompson</i> MO1051 | | | | 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Prostate Cancer Due to (or as a consequence of): b. Cerebrovascular event; C.V.A. Due to (or as a consequence of): c. right sided hemiplegia Due to (or as a consequence of): d. Urinary tract infection | | | | Approximate Interval Between Onset and Death | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PARKINSON'S disease, degenerative APHASIA | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <i>Joan Smith, D.O.</i> | | | | |
| 29c. License number H48286 | | | | 29d. Date signed (Month, Day, Year) 8-9-99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOAN Smith D.O. 540 Riverside Dr. Suite 8 | | | | 31. Date filed (Month, Day, Year) AUG 09 1999 | | | | |
| 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

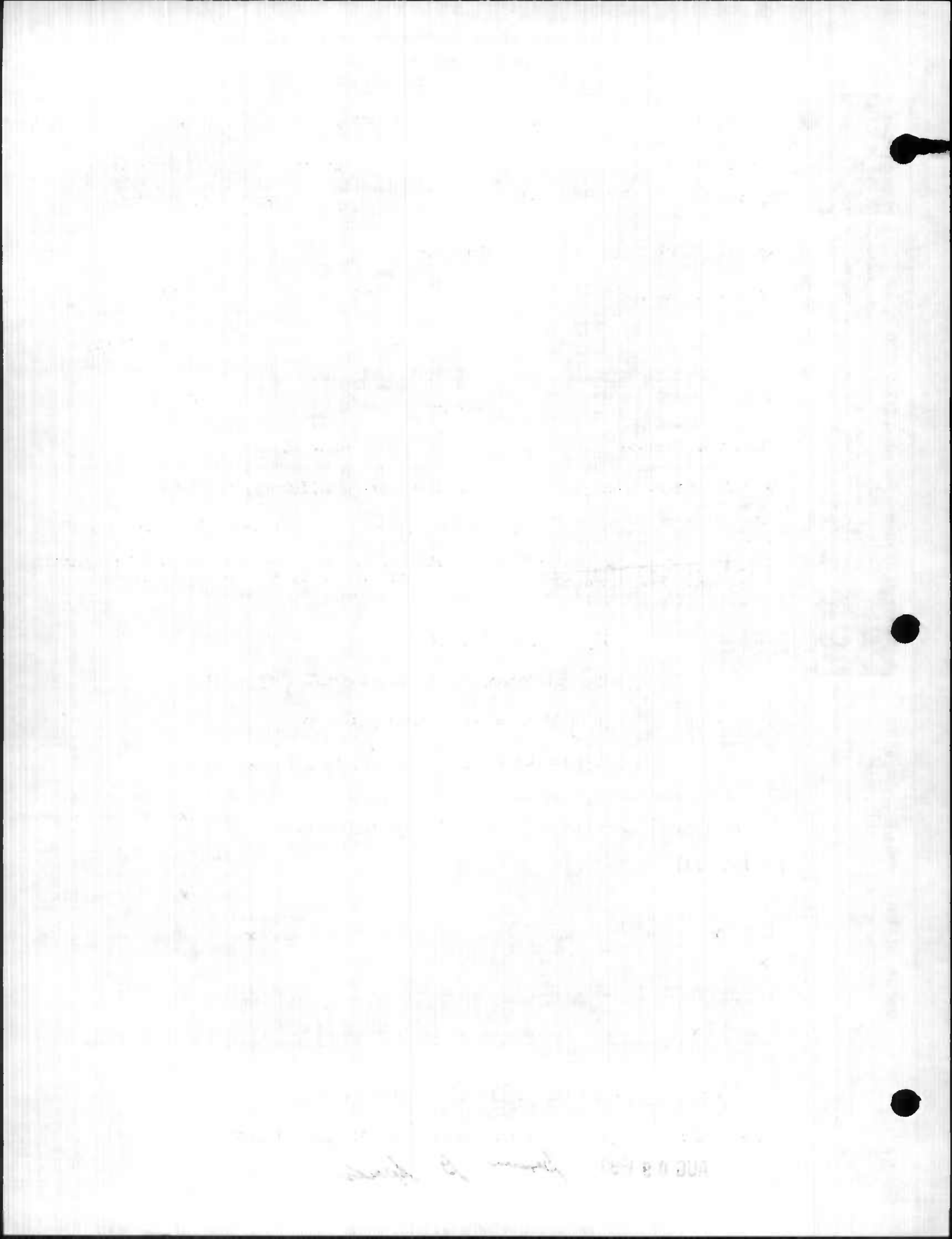
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26862

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE MARIE JONES

2. Date of Death

Month Day Year
AUGUST 7, 1999

3. Time of Death

17:03 p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

214-26-3844

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 3, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Huntingtown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4001 Houston Lane

10f. Zip Code

20639

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Someone else's home

17. Father's Name (First, Middle, Last)

Robert

Jacks

18. Mother's Name (First, Middle, Maiden Surname)

Emma

Rice

19a. Informant's Name/Relationship (Type, Print)

Ronald Jones/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4009 Houston Lane Huntingtown, MD 20639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Patuxent UM Church Cem. 8/13/99

Data

20c. Location - City or Town, State

Huntingtown, MD

21. Signature of Funeral Service Licensee

▶ Gladys A. Sewell

22. Name and Address of Facility

Sewell Funeral Home

1451 Dares Beach Road Prince Frederick, MD 20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Atherosclerotic Coronary -

b. Due to (or as a consequence of):

Vascular Disease

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Heart Disease

Hx. recent T.I.A.

Hx. Abnormal M.R.G.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ M. P. Shah

29c. License number

D-22634

29d. Date signed (Month, Day, Year)

8-8-99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. MAHESH P SHAH, M.D. Prince Frederick, Maryland 20678

State
Registrar

31. Date filed (Month, Day, Year)

AUG 11 1999

32. Registrar's Signature

M. Sparks
Benita B. Sparks

Baltimore, Maryland 21215-0020

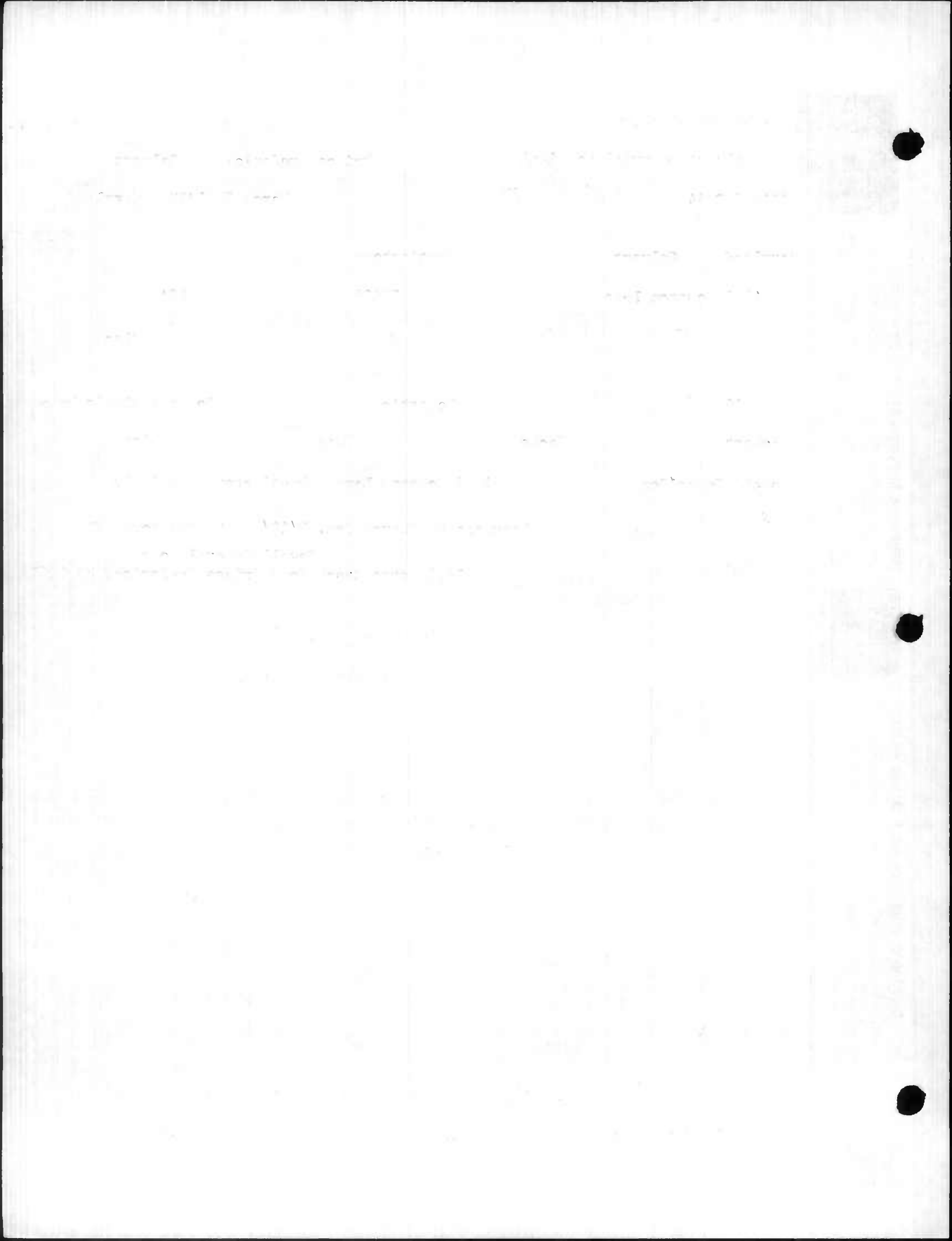
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26863

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HOWARD T. KING

2. Date of Death

Month Day Year
JULY 31, 1999 13:18

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Funeral
Director

5. Social Security Number

409-42-4434

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Nov. 6, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
Calvert

10c. City, Town or Location

Lusby

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1015 Coster Road

10f. Zip Code

20657

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No 1942-
If Yes, Give Year or Dates: 194513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

John Albert King

18. Mother's Name (First, Middle, Maiden Surname)

Frances Stewart

19a. Informant's Name/Relationship (Type, Print)

Rachel Smith/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1015 Coster Road Lusby, MD 20657

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Brooks UM Church Cemetery 8/6/99

Data

20c. Location - City or Town, State

St. Leonard, MD

21. Signature of Funeral Service Licensee

Bladys A. Sewell

22. Name and Address of Facility

Sewell Funeral Home
1451 Dares Beach Road Prince Frederick, MD 2067823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Cerebrovascular accident
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

8 hours

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis

Congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Joyce L. Owens, M.D.

29c. License number

D47313

29d. Date signed (Month, Day, Year)

7/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Joyce L. Owens, M.D., Prince Frederick, MD. 29678

31. Date filed (Month, Day, Year)

AUG 05 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4 +)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26864

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HARRY RAYMOND LYONS

2. Date of Death

Month Day Year
AUGUST 13 1999

3. Time of Death

0520

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL @EASTON

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

Funeral
Director

5. Social Security Number

220-01-6710

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG. 22, 1922

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

30588 KINGSTON ROAD

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

-0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FARMER

16b. Kind of Business/Industry

AGRICULTURE

17. Father's Name (First, Middle, Last)

HARRY H. LYONS

18. Mother's Name (First, Middle, Maiden Surname)

ESTELLE FIRST

19a. Informant's Name/Relationship (Type, Print)

M. BURNETT LYONS / BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30588 KINGSTON ROAD, EASTON, MD 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SPRING HILL CEMETERY

Date

8-16-99

20c. Location - City or Town, State

EASTON, MD 21601

21. Signature of Funeral Service Licensee

M. E. Newnam CFSP

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 S. HARRISON ST., EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Charles E. DiNapolitano

29c. License number

D38990

29d. Date signed (Month, Day, Year)

8-13-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

404 MARVEL COURT, EASTON, MD, 21601

31. Date filed (Month, Day, Year)

AUG 13 1999

32. Registrar's Signature

B. Sparks

State
RegistrarHARRY RAYMOND LYONS
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

201 E. Main St. - 100

Handwritten signature or initials

DUPLICATE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26865

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

AARON LESTER LEWIS

2. Date of Death

Month Day Year
August 12 1999

3. Time of Death

10:20pm

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

577-09-5150

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
APRIL 25, 1915

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ST. MARY'S

10c. City, Town or Location

CHARLOTTE HALL

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

38285 PLEASANT VIEW DRIVE

10f. Zip Code

20622

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No U.S.A.
If Yes, Give Year or Dates: 1941-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MEAT CUTTER

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

SAMUEL JUDSON LEWIS

18. Mother's Name (First, Middle, Maiden Surname)

LELIA BRYANT

19a. Informant's Name/Relationship (Type, Print)

MICHAEL E. DECESARIS/SON-IN-LAW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

615 UNIVERSITY DR., WALDORF, MARYLAND 20602

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

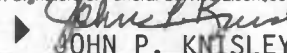
RESURRECTION CEMETERY

Date

8/16/1999 CLINTON, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

JPK  JOHN P. KNISLEY

MO1164

22. Name and Address of Facility

THE HUNT FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MARYLAND 20604-0156

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cardiorespiratory arrest

Due to (or as a consequence of):

b.

Arteriosclerotic cardiovascular disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

24 hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 Waheed U. Akhtar

29c. License number

D-31675

29d. Date signed (Month, Day, Year)

13 Aug 99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

White Plains Medical Center
Waheed U. Akhtar, MD P.O. Box 1737 White Plains, Maryland 20695

31. Date filed (Month, Day, Year)

AUG 17 1999

32. Registrar's Signature



State
Registrar

Aaron Lewis

Baltimore, Maryland 21215-0020

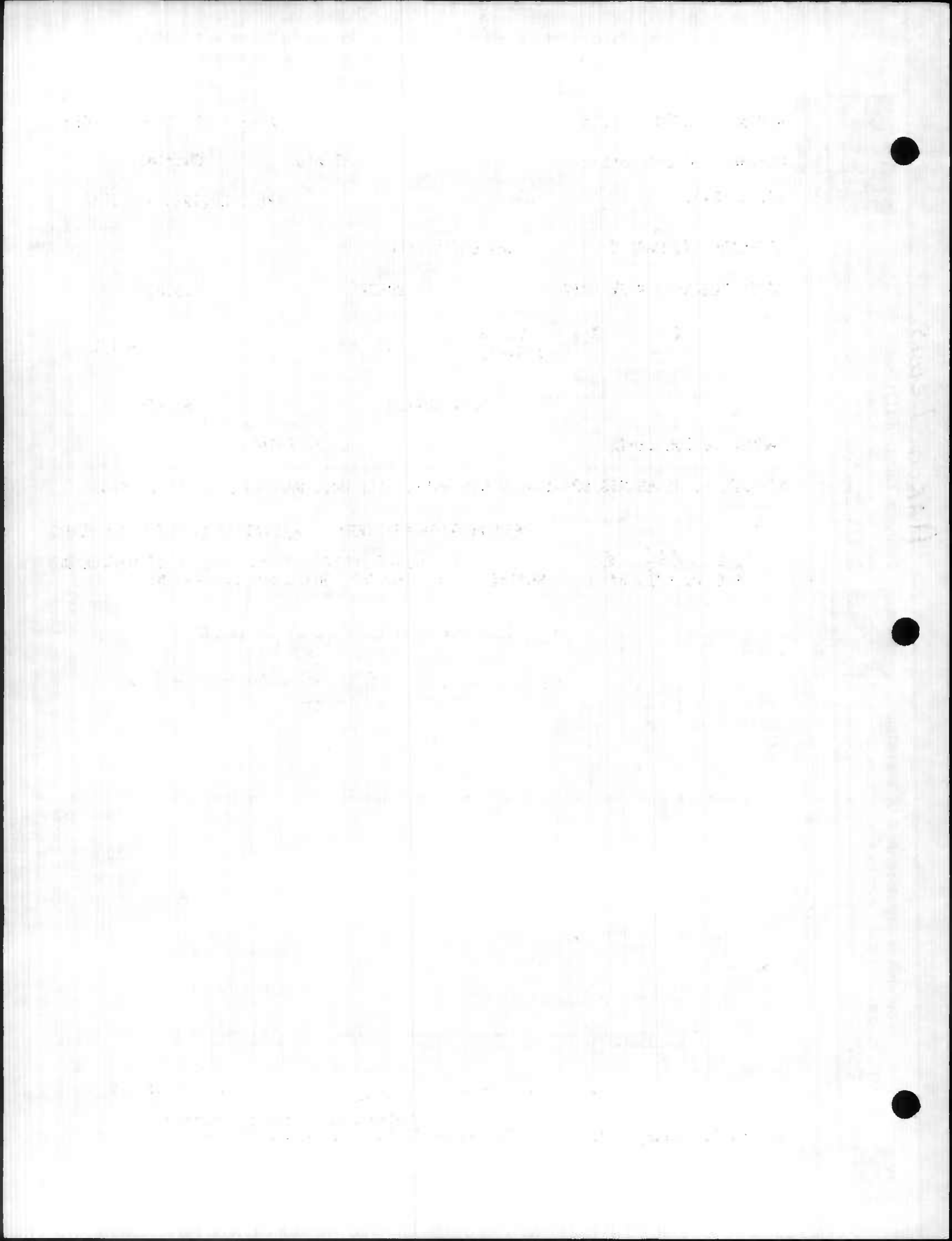
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26866

| | | | | | | | | |
|--|---|--|--|---|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Zoilus Joel LeMay, Jr. | | | | 2. Date of Death Month Day Year July 31, 1999 | | 3. Time of Death 8:00 A.M. | |
| | 4e. Facility Name (If not institution, give street and number) 11450 Asbury Circle, Apt. #320 | | | | 4b. City, Town, or Location of Death Solomons | | 4c. County of Death Calvert | |
| Funeral Director | 5. Social Security Number 240-48-0042 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 66 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Aug. 29, 1932 | | 9. Birthplace (State or Foreign Country) Washington, DC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Calvert | | 10c. City, Town or Location Solomons | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 11450 Asbury Circle, Apt. #320 | | | | 10f. Zip Code 20688 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korea | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Printer | | | 16b. Kind of Business/Industry Federal Government | |
| 17. Father's Name (First, Middle, Last) Zoilus J. LeMay | | | | 18. Mother's Name (First, Middle, Maiden Surname) Frances L. Parrish | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Martha LeMay (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11450 Asbury Circle, Apt. #320, Solomons, MD 20688 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MD. Veterans Cemetery Aug. 5, 99 Cheltenham, Maryland | | | 20c. Location - City or Town, State | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Lee Funeral Home, Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Resp failure Due to (or as a consequence of): b. Cardio-resp arrest Due to (or as a consequence of): c. Dementia Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD Recurrent Pneumonia | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier [Signature] MD | | 29c. License number D50290 | | 29d. Date signed (Month, Day, Year) 8/3/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dhiren Shah, MD 110 Hospital Road, Suite #303, Prince Frederick, MD 20678 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature [Signature] | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26867

| | | | | | | | | | | |
|---|--|---|--|---|--|--------------------------|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jessie W. Lockwood | | | | 2. Date of Death Month Day Year July 27 1999 | | | | 3. Time of Death 3:38PM | |
| | 4a. Facility Name (If not institution, give street and number) Waldorf Health Care Center | | | | 4b. City, Town, or Location of Death LaPlata | | | | 4c. County of Death Charles | |
| Funeral Director | 5. Social Security Number 250 12-7013 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) March 9, 1920 | | 9. Birthplace (State or Foreign Country) Georgia | |
| | Usual Residence of Decedent | | | | 10a. State MD | | 10b. County Charles | | 10c. City, Town or Location LaPlata | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 6363 Hawkins Gate Road | | | | 10f. Zip Code 20646 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aviation Specialist | | | | 16b. Kind of Business/Industry Federal Government | | |
| 17. Father's Name (First, Middle, Last) James Monroe Watson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Anna Mulkey | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Susan Sheriff (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6363 Hawkins Gate Road, LaPlata, Maryland 20646 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery July 31, 1999 | | | | 20c. Location - City or Town, State Suitland, Maryland | | |
| 21. Signature of Funeral Service Licensee Kelli R. Patter | | | | 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. FAILURE TO THRIVE WEEKS Due to (or as a consequence of): b. CARCINOMA OF PANCREAS MONTH Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES SEIZURE DISORDER | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Ashvin Patel | | | | 29c. License number D. 44436 | | |
| 29d. Data signed (Month, Day, Year) July 28 1999 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashvin Patel, M.D. #6 Industrial Park Dr. 6B Waldorf, Md. | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 29 1999 | | | | 32. Registrar's Signature Benita G. Spauld | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26868

| | | | | | | | | | |
|---|--|---|--|--|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) FRANCES BARNES MORMANN | | | | 2. Date of Death Month Day Year AUG. 11 1999 | | 3. Time of Death 4:46 AM | | |
| | 4a. Facility Name (If not institution, give street and number) SHORE NURSING AND REHABILITATION CENTER | | | | 4b. City, Town, or Location of Death DENTON | | 4c. County of Death CAROLINE | | |
| Funeral Director | 5. Social Security Number 215-07-8429 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) MAR. 26, 1909 | | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MD | | 10b. County CAROLINE | | 10c. City, Town or Location DENTON | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 420 COLONIAL DRIVE | | 10f. Zip Code 21629 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK | | 16b. Kind of Business/Industry DEPT. STORE | | | |
| 17. Father's Name (First, Middle, Last) CHARLES BARNES | | | | 18. Mother's Name (First, Middle, Maiden Surname) AMELIA EASON | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ELIZABETH BARNES/ SISTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 NORTH STREET, EASTON, MD 21601 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) SPRING HILL CEMETERY | | Date 8-14-99 | | 20c. Location - City or Town, State EASTON, MD | | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> CFSP | | 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 | | | | | | | |
| 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute leukemia Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death 6mo. | | | |
| Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> MD | | 29c. License number D35284 | | 29d. Date signed (Month, Day, Year) 8/11/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREA ALLEN MD 219 S. Washington St Easton MD 21601 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 13 1999 | | 32. Registrar's Signature <i>[Signature]</i> B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

[illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26869

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Johnny

Makle

2. Date of Death

August 13, 1999

3. Time of Death

3:00 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

16611 Candy Hill Road

4b. City, Town, or Location of Death

Upper Marlboro

4c. County of Death

Prince Georges

5. Social Security Number

212-34-9794

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

August 5, 30

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

16611 Candy Hill Road

10f. Zip Code

20772

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Pyles Lumber Co.

17. Father's Name (First, Middle, Last)

Rome Makle

18. Mother's Name (First, Middle, Maiden Surname)

Maragret

Fowler

19a. Informant's Name/Relationship (Type, Print)

Christine Johnson/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16611 Candy Hill Rd, Upper Marlboro MD 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Philips Ch. Cem Aug. 19, 99 Aquasco MD 20608

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Adams Funeral Home P.A. Aquasco MD 20608

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Lung Cancer with Brain Metastasis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D38698

29d. Date signed (Month, Day, Year)

8/13/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Mitch Oh, MD 11340 Pombrooke Sq #201 Waldorf MD 20603

31. Date filed (Month, Day, Year)

AUG 17 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-26870

0002 8/16/99 Dr. Eltgroth
Baltimore, Maryland 21215-0020
0002 Alice Lillian Meck
Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020

| | | | | | | | | |
|---|---|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Alice Lillian Meck | | | | 2. Date of Death Month Day Year August 16, 1999 | | 3. Time of Death 0002 | |
| | 4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital | | | | 4b. City, Town, or Location of Death Havre de Grace | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 214-26-3154 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 69 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 12, 1929 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10. Usual Residence of Decedent 10a. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location Port Deposit | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 120 Linton Run Road | | 10f. Zip Code 21904 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Twelve Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Caregiver | | 16b. Kind of Business/Industry Lighthouse Christian Day Care Pleasant View Baptist Church Port Deposit, Maryland | | | |
| | 17. Father's Name (First, Middle, Last) Ralph Lynch | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Wiggins | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Donald Meck (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Linton Run Road, Port Deposit, Maryland 21904 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hopewell Cemetery | | 20c. Location - City or Town, State Port Deposit, Maryland | | 20d. Date 8/19/99 | |
| | 21. Signature of Funeral Service Licensee Thomas M. Patterson, Sr. | | | | 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903-0188 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Intracranial Hemorrhage | | | | | | | |
| | 23b. Approximate Interval Between Onset and Death hours | | | | | | | |
| | 23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and Title of Certifier Stephen Eltgroth MD | | 29c. License number D0053622 | | 29d. Date signed (Month, Day, Year) 8/17/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN ELTGROTH MD 319 S. Union Ave HLG MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 17 1999 | | 32. Registrar's Signature Brenda B. Sparks | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26871

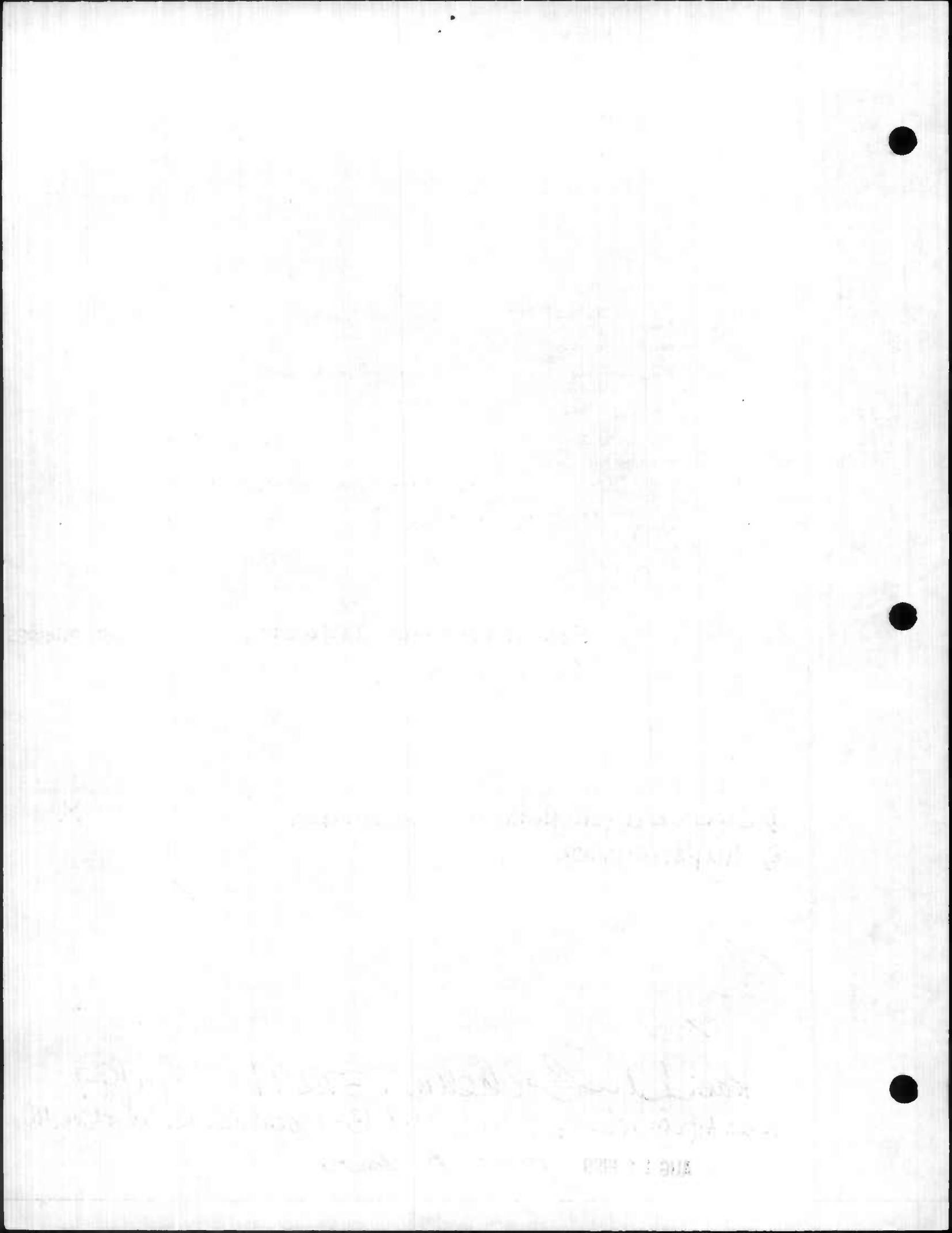
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edward Franklin Mauk, Sr. | | | | 2. Date of Death Month Day Year August 10, 1999 | | 3. Time of Death 2:44 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 214-12-4613 | 8. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 88 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 4, 1911 | | 9. Birthplace (State or Foreign Country) Pennsylvania |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Galesville | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 4844 Church Lane | | | | 10f. Zip Code 20765 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter | | | 16b. Kind of Business/Industry Boat Building | |
| 17. Father's Name (First, Middle, Last) Albert S. Mauk | | | | 18. Mother's Name (First, Middle, Maiden Surname) Caroline Coughenour | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Georgie Lee Mauk/ Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4844 Church Lane Galesville, MD 20765 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Woodfield Cemetery | | 20c. Location - City or Town, State 8-13-99 Galesville, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sudden Cardiac arrest Due to (or as a consequence of): b. Cardiac dysrhythmia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 30 minutes |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1) Cardiac dysrhythmia with pacemaker 2) hypertension | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Kae A. Bichel MD | | | | 29c. License number D37291 | | 29d. Date signed (Month, Day, Year) 8/11/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kae A. Bichel MD 134 Owensville Rd West River MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1999 | | | | 32. Registrar's Signature B. Sparks | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26872

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---|---|--|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Julia A. Majerowicz | | | | 2. Date of Death Month Day Year August 9, 1999 | | | | 3. Time of Death 15:34 | |
| | 4a. Facility Name (If not institution, give street and number) North Arundel Hospital | | | | 4b. City, Town, or Location of Death Glen Burnie | | | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 217-26-7641 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 69 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) Jan 2, 1930 | | 9. Birthplace (State or Foreign Country) Maryland | | Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Pasadena | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 716 Pasadena Road | | | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Personnel Administrator | | | 16b. Kind of Business/Industry Department of Transportation | | | |
| 17. Father's Name (First, Middle, Last) Walter Kaminski | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rose Wolak | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) William Majerowicz / Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 Pasadena Road Pasadena, MD 21122 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial | | Date Aug 12 1999 | | 20c. Location - City or Town, State Elkridge, MD | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Barranco & Sons P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 | | | | | | |
| 23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure | | | | | | | | Approximate interval Between Onset and Death 2 years | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. c. d. | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner | | | | 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number 027938 | | | | 29d. Date signed (Month, Day, Year) 8/11/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mayer Gorbatsky, 795 Agawam Rd. Glen Burnie MD 21061 | | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year) AUG 12 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

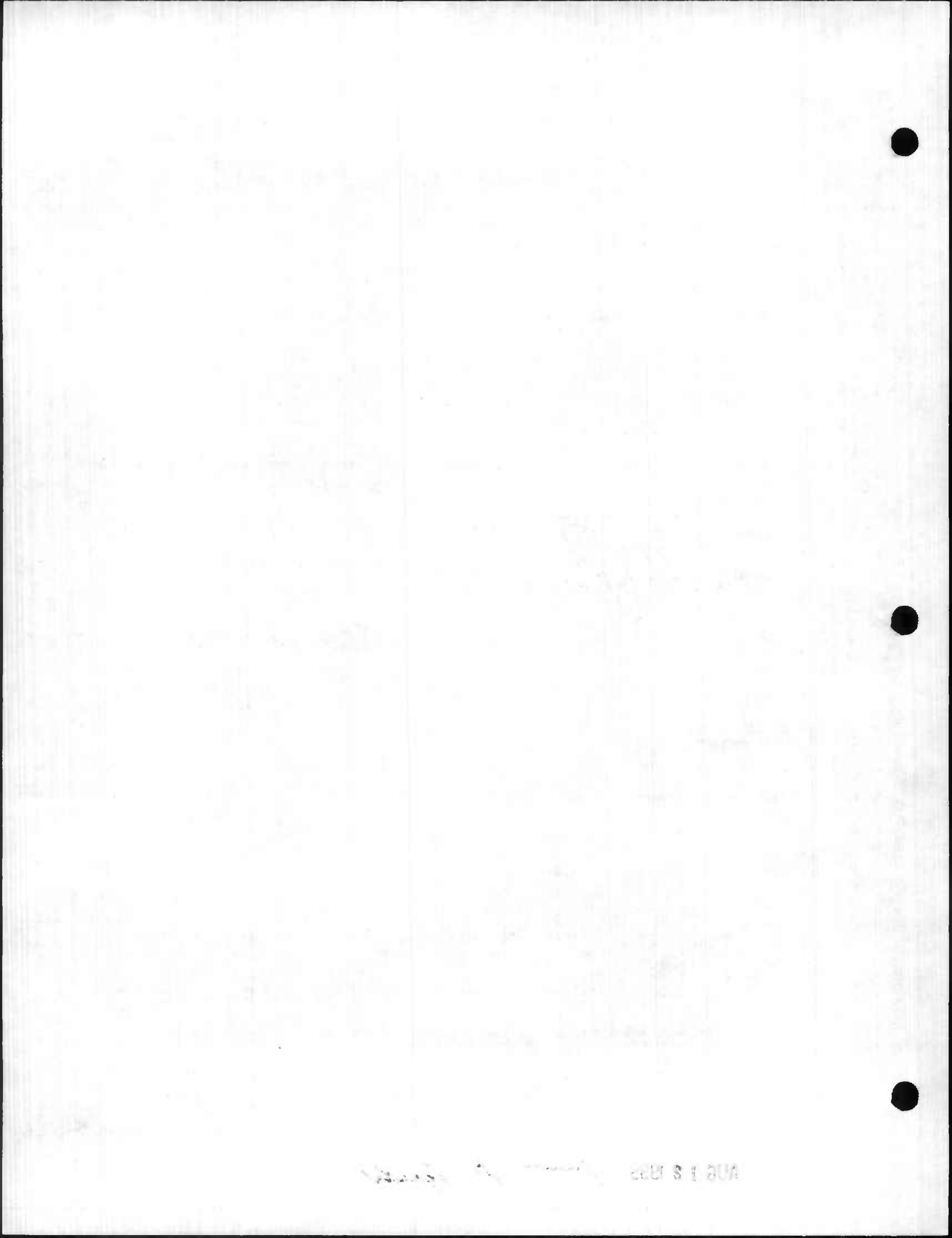
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

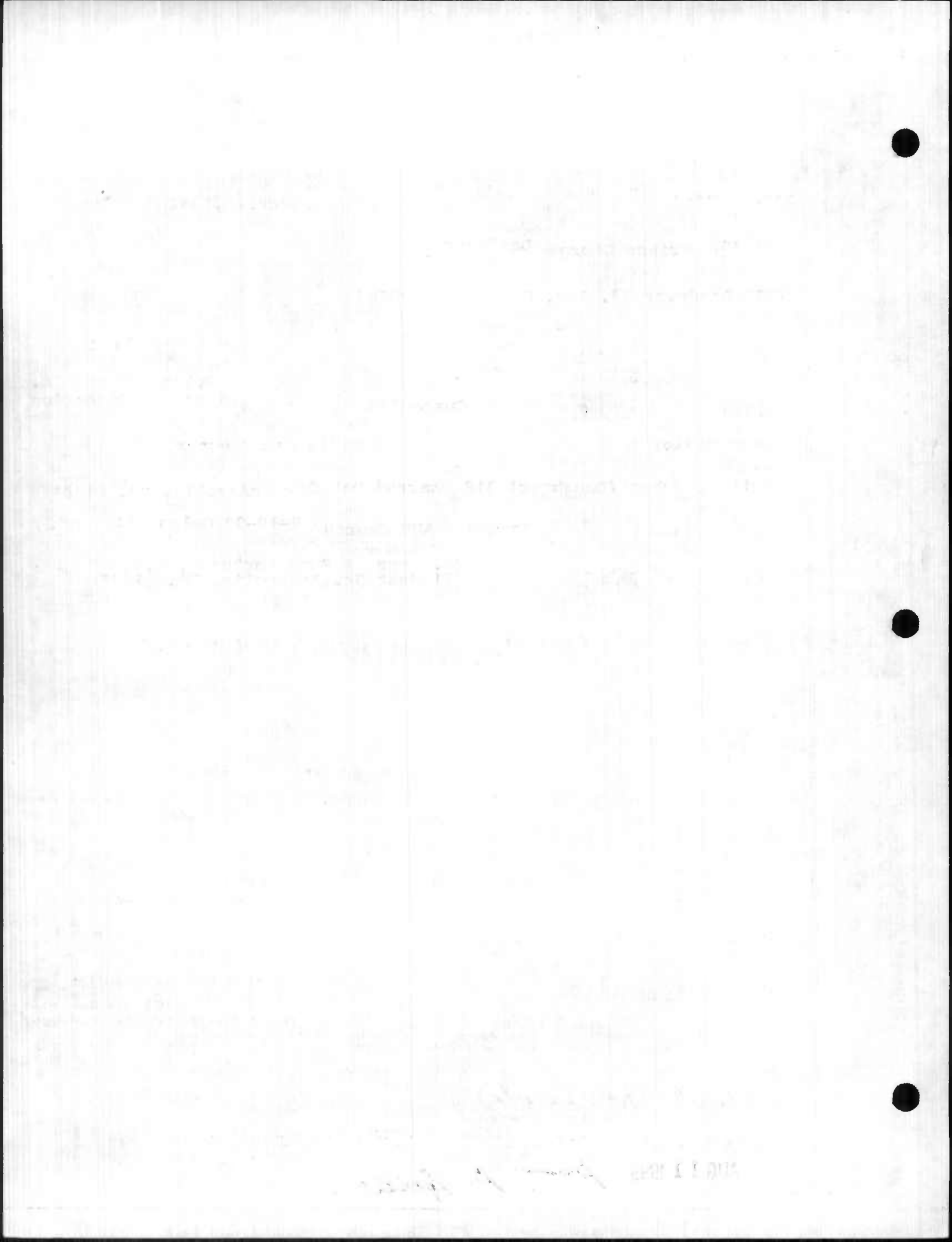
Reg. No.

99 26873

| | | | | | | | | |
|--|--|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Izel Medley Jr. | | | | 2. Date of Death Month Day Year August 04 1999 | | 3. Time of Death 08:09 PM. | |
| | 4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center | | | | 4b. City, Town, or Location of Death Cheverly | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 212-40-3463 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 56 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 29, 1942 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) Maryland | | 10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10a. State Maryland | | 10b. County Prince George | | 10c. City, Town or Location Landover | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 7330 Landover Rd. Apt. C | | | | 10f. Zip Code 20785 | | 10g. Citizen of What Country? US | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian | | 16b. Kind of Business/Industry Prince George Co. Board of Education | | |
| 17. Father's Name (First, Middle, Last) Issacc Medley | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sadie Mae Crowner | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Sheril Pritchett (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 Charred Oak Ct. Annapolis, Md. 21401 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ebenezer AME Church | | 20c. Location - City or Town, State 8-10-99 Galesville, Md. | | | | |
| 21. Signature of Funeral Service Licensee Larry D. Reese | | | | 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 | | | | |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Contact Gunshot wound of the head Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? Limited <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 8-4-99 | | 28b. Time of Injury 1522 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred subject shot self | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Parking Lot | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4908 Marlboro Pike Prince Georges County, Maryland | | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Stephen S. Radentz, MD | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) August 5, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | | | 32. Registrar's Signature [Signature] | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



99 26874

1. Decedent's Name (First, Middle, Last) John Charles Cleveland Mister, Sr. 2. Date of Death July 25 1999 3. Time of Death 1:15 AM

4a. Facility Name (If not institution, give street and number) Box 350 Adelina Road 4b. City, Town, or Location of Death Prince Frederick Calvert 4c. County of Death

5. Social Security Number 213 34 5514 6. Sex M 67 7. Age (In yrs. last birthday) 67 8. Date of Birth Sept 9 1931 9. Birthplace (State or Foreign Country) Maryland

10a. State Maryland 10b. County Prince Frederick 10c. City, Town or Location 10d. Inside City Limits 10e. Street and Number Box 350 Adelina Road 10f. Zip Code 20678 10g. Citizen of What Country? United States

11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify White

15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last) John Franklin Mister 18. Mother's Name (First, Middle, Maiden Surname) Burdette Ruth Skur

19a. Informant's Name/Relationship (Type, Print) Lorena V Mister- wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 350 Adelina Rd. Prince Frederick MD 20678

20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State

21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Island Rd. Port Republic MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Kidney cancer Due to (or as a consequence of): 1 year

23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. congestive heart failure coronary artery disease

23c. Did tobacco use contribute to the cause of death? 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 26d. Describe how injury occurred

29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul V Pomilla, M.D. Prince Frederick MD 20678

31. Date filed (Month, Day, Year) JUL 27 1999 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26875

Amend #15, 9th, #17, Sencie, 7/29/99, drw Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marie Grace Maggio | | | | 2. Date of Death Month Day Year July 23, 1999 | | 3. Time of Death 9:45AM | |
| | 4a. Facility Name (If not institution, give street and number) 1903 Thornton Drive | | | | 4b. City, Town, or Location of Death Ft. Washington | | 4c. County of Death Prince George | |
| Funeral Director | 5. Social Security Number 579 818-32-1676 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 | | 8. Date of Birth (Month, Day, Year) 5-13-27 | |
| | 9. Birthplace (State or Foreign Country) Wash. D.C. | | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Clinton | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 6022 Chris-Mar Avenue | | 10f. Zip Code 20735 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th - 8th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounts Payable Clerk | | 16b. Kind of Business/Industry Federal Government | | 16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounts Payable Clerk | | |
| 17. Father's Name (First, Middle, Last) Sencie Seaborn | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Cage | | 19a. Informant's Name/Relationship (Type, Print) Steven E. Maggio, Sr. (Husband) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6022 Chris-Mar Avenue Clinton Maryland 20735 | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery | | 20c. Location - City or Town, State Brentwood Maryland | | 20d. Date of Disposition July 28, 1999 | | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of Breast Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death 18 months | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D46478 | | 29d. Date signed (Month, Day, Year) 7-26-99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Suresh Patel, M.D. 7501 Surratts Rd. # 307 Clinton, Md. 20735 | | 31. Date filed (Month, Day, Year) JUL 26 1999 | | 32. Registrar's Signature | | 33. Registrar's Name B. Spauld | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26876

| | | | | | |
|--|---|--|--|--|------------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Diane Mullens | | 2. Date of Death Month July Day 19 Year 1999 | | 3. Time of Death 6:50am |
| | 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death P.G. |
| Funeral Director | 5. Social Security Number 212-52-6066 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 50 Yrs. | 8. Date of Birth (Month, Day, Year) Sept 8, 1948 | |
| | 9. Birthplace (State or Foreign Country) Washington DC | | 10. Usual Residence of Decedent | | |
| 10a. State MD | | 10b. County Charles | | 10c. City, Town or Location Waldorf | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 5013 Nicholas Road | | 10f. Zip Code 20601 | |
| 10g. Citizen of What Country? United States | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Homemaker | | 17. Father's Name (First, Middle, Last) Robert O. Bryant | |
| 18. Mother's Name (First, Middle, Maiden Surname) Betty Cheamault | | 19a. Informant's Name/Relationship (Type, Print) Douglas Mullens (HUSBAND) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5013 Nicholas Drive, Waldorf, Maryland 20601 | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery | | 20c. Location - City or Town, State Cheltenham, Maryland | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Conchial Standstill Due to (or as a consequence of):</p> <p>b. Coronary artery disease Due to (or as a consequence of):</p> <p>c. Severe Hypertension Due to (or as a consequence of):</p> <p>d.</p> | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number 014767 | | 29d. Date signed (Month, Day, Year) 7/29/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CYRUS V. PARSELEY M.D. 8700 Old Branch Ave Clinton MD 20735 | | | | | |
| 31. Date filed (Month, Day, Year) 7/29/99 JUL 23 1999 | | 32. Registrar's Signature | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

6

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Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "of" are visible.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26877

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) John Wesley Meredith | | | | 2. Date of Death Month July , Day 30 , Year 1999 | | 3. Time of Death 6:26 P.M. | |
| 4a. Facility Name (If not institution, give street and number) 6350 Dant Drive | | | | 4b. City, Town, or Location of Death Owings | | 4c. County of Death Calvert | |
| 5. Social Security Number 218-54-7302 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 50 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 30, 1948 | |
| 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | | | | |
| 10b. County Calvert | | 10c. City, Town or Location Owings | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 6350 Dant Drive | | | | 10f. Zip Code 20736 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician | | 16b. Kind of Business/Industry Commerical Building | |
| 17. Father's Name (First, Middle, Last) George Lockett Meredith | | | | 18. Mother's Name (First, Middle, Maiden Surname) Virginia Dell Rudy | | | |
| 19a. Informant's Name/Relationship (Type, Print) Joy Arlyn Meredith (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6350 Dant Drive, Owings, Maryland 20736 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory | | Date July 31, 1999 | | 20c. Location - City or Town, State Clinton, Maryland | |
| 21. Signature of Funeral Service Licensee B. G. Gith | | | | 22. Name and Address of Facility Lee Funeral Home, Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) colon cancer with liver metastasis e. Due to (or as a consequence of): Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 3 months | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier Bruce A. Silver MD | | | | 29c. License number 021463 | | 29d. Date signed (Month, Day, Year) 7-31-99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bruce A. Silver MD 110 Hospital Rd, Su. 110, Prince Frederick, MD 20678 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature B. Sparks | | | |

To Be Completed by Funeral Director

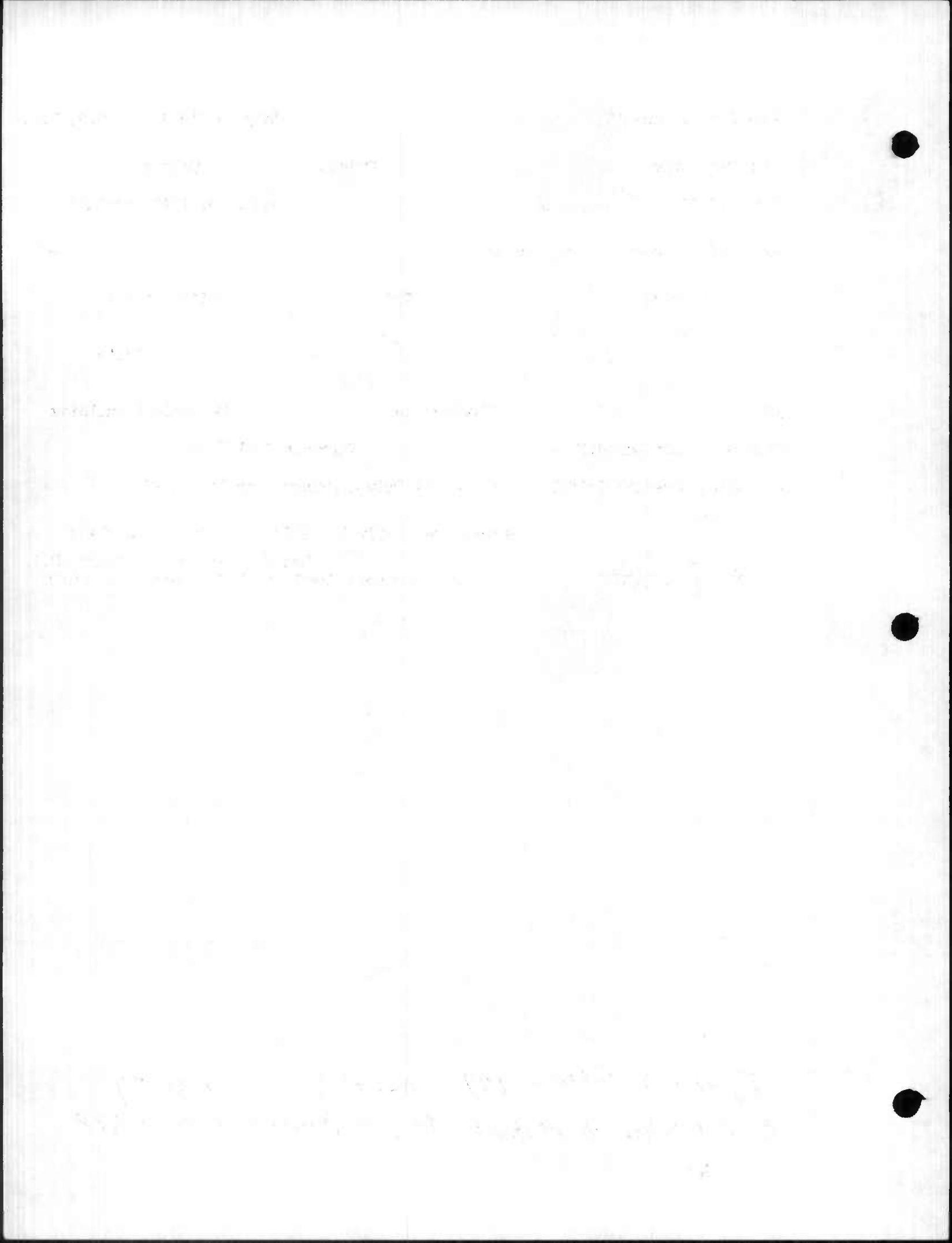
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26878

| | | | | | | | | |
|---|--|---|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Larry Mackey | | | | 2. Date of Death Month July Day 29 Year 1999 | | 3. Time of Death 08:15 PM. | |
| | 4a. Facility Name (If not institution, give street and number) 3132 Brinkley Road #304 | | | | 4b. City, Town, or Location of Death Temple Hills | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 055-42-7437 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 47 Yrs. | | 8. Date of Birth (Month, Day, Year) July 20, 1952 | |
| | 9. Birthplace (State or Foreign Country) Bronx, N.Y. | | 10a. State MD | | 10b. County P.G. | | 10c. City, Town or Location Camp Springs | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 3132 Brinkley Road #304 | | 10f. Zip Code 20748 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mail Handler | | 16b. Kind of Business/Industry U.S. Postal Service | | | | |
| 17. Father's Name (First, Middle, Last) Harry A. Mackey, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Summa) Viola James | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Pablita Mackey (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5205 Alderney Place, Camp Springs, Maryland 20748 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Calverton National Cem. | | 20c. Location - City or Town, State Calverton, New York | | 20d. Date Aug 5th 1999 | | |
| 21. Signature of Funeral Service Licensee Keeli R. Patter | | | | 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? Limited <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Stephen S. Radentz, M.D. | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) July 30, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | | | 32. Registrar's Signature Benita B. Sparks | | | | |

Baltimore, Maryland 21215-0020

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26879

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHANNA

MACKALL

2. Date of Death

JULY 29, 1999

3. Time of Death

22:53

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

213-22-1348

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 5, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Sunderland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6975 Old Solomons Island Road

10f. Zip Code

20789

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

Harvey

Carr

18. Mother's Name (First, Middle, Maiden Surname)

Ollie

(unknown)

19a. Informant's Name/Relationship (Type, Print)

Alice Height/Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 424 Owings, MD 20736

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Solid Rock Church Cem.

Date

8/3/99

20c. Location - City or Town, State

Port Republic, MD

21. Signature of Funeral Service Licensee

Blodge A. Sewell

22. Name and Address of Facility

Sewell Funeral Home

1451 Dares Beach Rd. Prince Frederick, MD 20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

b. Diabetes Mellitus

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Julie O'Keefe MD

29c. License number

D52192

29d. Date signed (Month, Day, Year)

July 31 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JULIE A. O'KEEFE, M.D., PRINCE FREDERICK, MD 20678

31. Date filed (Month, Day, Year)

AUG 01 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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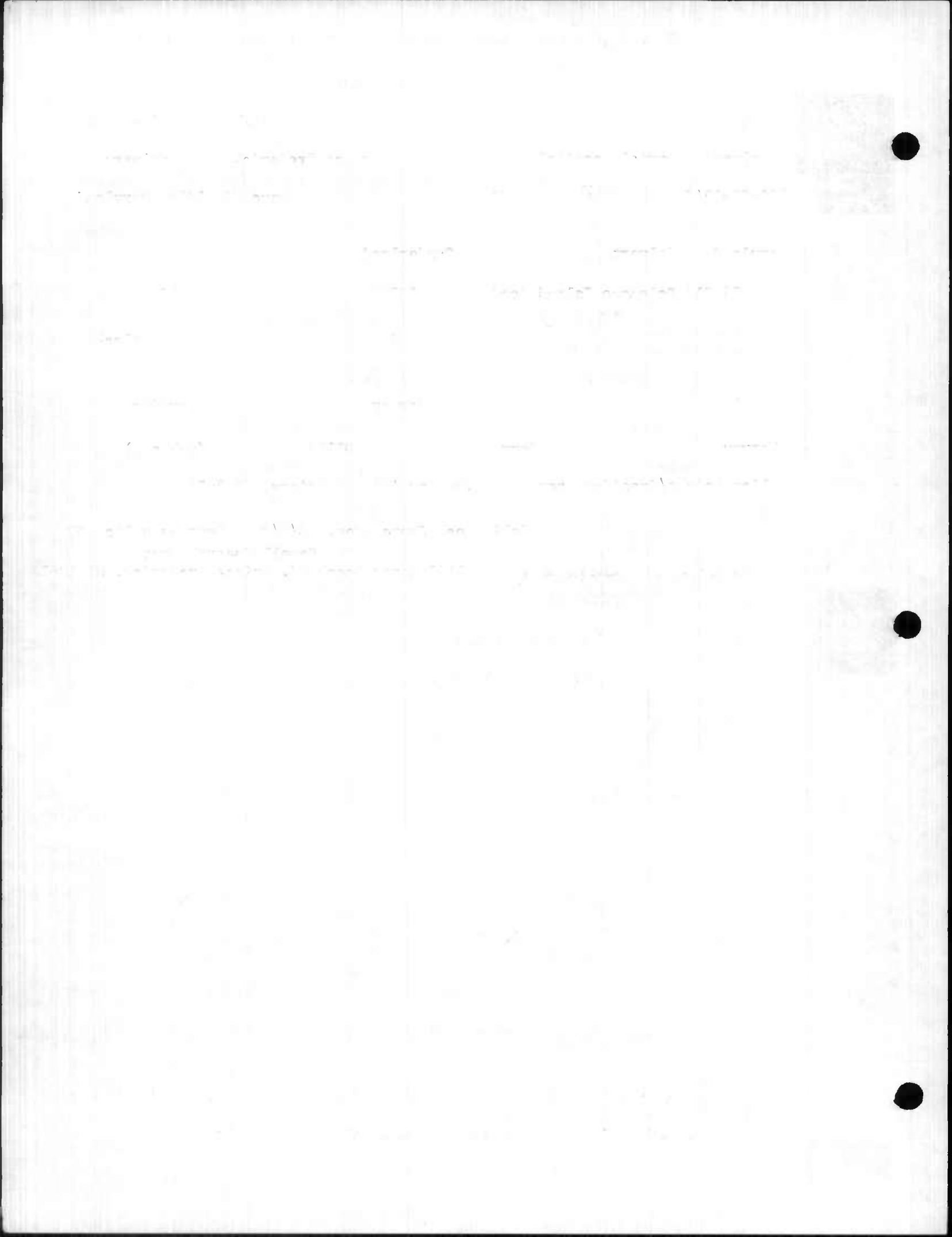
Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26880

| | | | | | | | | |
|---|--|--|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Walter Maddox, Sr. | | | | 2. Date of Death Month Day Year August 4, 1999 | | 3. Time of Death 10:00 AM | |
| | 4a. Facility Name (If not institution, give street and number) Salisbury Center: Genesis ElderCare | | | | 4b. City, Town, or Location of Death Salisbury, MD | | 4c. County of Death Wicomico | |
| Funeral Director | 5. Social Security Number 218-30-1187 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 28, 1920 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Wicomico | | 10c. City, Town or Location Salisbury | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 222 Hazel Avenue | | 10f. Zip Code 21801 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) laborer | | 16b. Kind of Business/Industry Deer's Head State Ctr. | | 17. Father's Name (First, Middle, Last) George W. Maddox | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Naomi Collins | | 19a. Intendant's Name/Relationship (Type, Print) Margaret Maddox/wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Hazel Avenue - Salisbury, Maryland 21801 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Samuel Wesley Church Cem. | | 20c. Location - City or Town, State Manokin, Maryland | | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Jolley Memorial Chapel MD 21801 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 8/07/99 | | |
| 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number DB9813 | | |
| 29d. Date signed (Month, Day, Year) 8/4/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WATKINS 1104 Westbury Drive Salisbury MD 21804 | | 31. Date filed (Month, Day, Year) AUG 05 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26881

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SARA

VIRGINIA

MENNE

2. Date of Death
Month Day Year
August 6 1999

3. Time of Death

1223

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

214-10-6067

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 26, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

28706 Ocean Gateway

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

County Government

17. Father's Name (First, Middle, Last)

John Henry Dulany Williams

18. Mother's Name (First, Middle, Maiden Surname)

Lillie E. Hilghman

19a. Informant's Name/Relationship (Type, Print)

Virginia Perdue/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

721 Camden Ave., Salisbury, MD 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Springhill Memory Gardens

Date

8/10/99

20c. Location - City or Town, State

Hebron, MD

21. Signature of Funeral Service Licensee

David H. Thompson

MO1051

22. Name and Address of Facility

Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Cardiorespiratory Failure
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

40 mins

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary Artery Disease
Due to (or as a consequence of):

3 mos

c. Congestive Heart Failure
Due to (or as a consequence of):

3 mos

d. Old myocardial Infarction

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Helen M. Baldado

29c. License number

16840

29d. Date signed (Month, Day, Year)

8/9/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HELEN BALDADO, M.O. 547 F Riverside Dr. Salisbury, MD

31. Date filed (Month, Day, Year)

AUG 09 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

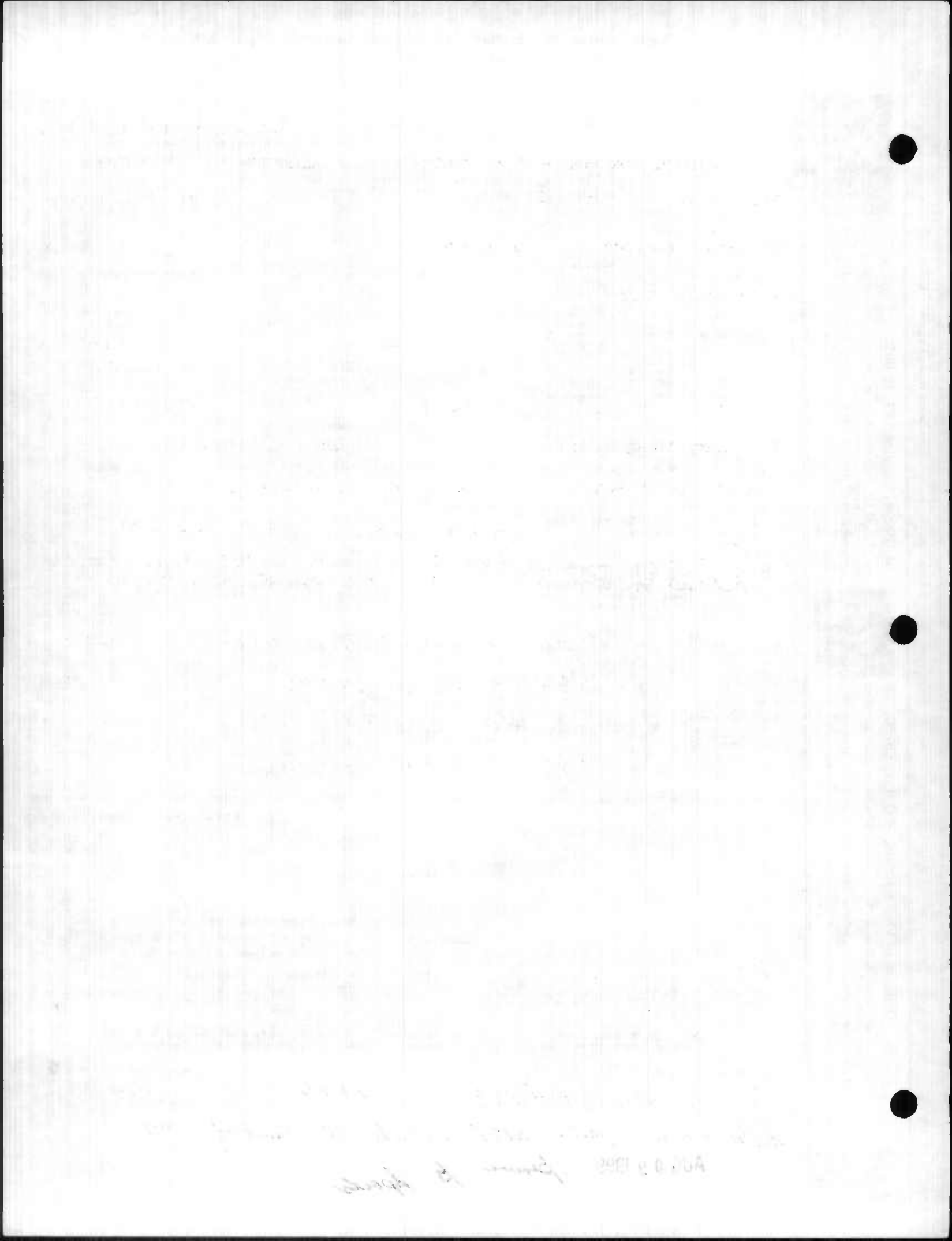
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26882

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN

RUTH

MILLER

2. Date of Death
Month Day Year

AUGUST

10

1999

3. Time of Death
4:15 PM

4a. Facility Name (If not institution, give street and number)

BERLIN NURSING & REHABILITATION CENTER

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

Funeral
Director

5. Social Security Number

164-14-0652

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

JAN. 24, 1920

9. Birthplace (State or Foreign
Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

BERLIN

10b. County

WORCESTER

10c. City, Town or Location

BERLIN

10d. Inside City Limits
1 ☒ Yes 2 ☐ No

10e. Street and Number

116 N. MAIN STREET

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status
1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: WHITE15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

WILFRED

JONES

18. Mother's Name (First, Middle, Maiden Surname)

HELEN

McCONNELL

19a. Informant's Name/Relationship (Type, Print)

CLIFTON B. THAW JR./SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 57, PITTSVILLE, MARYLAND 21850

20a. Method of Disposition
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

SALISBURY CREMATORY

Date

8/11/99

20c. Location - City or Town, State

SALISBURY, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Chronic Respiratory Failure

months

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Obstruction of Upper Respiratory tract

months

Due to (or as a consequence of):

c. Cancer of Vocal Cords

months

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe degenerative nutrition -

tracheostomy -

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D02026

29d. Date signed (Month, Day, Year)

Aug 11-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FREDERICO G. ARTHES, M.D., 46 TEAL CIRCLE, BERLIN, MD 21811

State
Registrar

31. Date filed (Month, Day, Year)

AUG 12 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26883

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Gable MUNDY

2. Date of Death

Month Day Year
AUGUST 6, 1999

3. Time of Death

6:15 P.M.

4a. Facility Name (If not institution, give street and number)

Berlin Nursing & Rehabilitation Ctr.

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

577 03 4157

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 10, 1905

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Ocean Pines

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4 Portside Court

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

proprietor

16b. Kind of Business/Industry

Clothing-retail

17. Father's Name (First, Middle, Last)

William Echols Foster

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Gable Clery

19a. Informant's Name/Relationship (Type, Print)

Jack W. Mundy (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

540 Small Reward Rd., Huntingtown, MD 20639

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

8-11-99

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service licensee

22. Name and Address of Facility

Rausch Funeral Home, Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure Weeks.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Coronary Artery Disease Year.

c. Atherosclerosis

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Small Bowel Obstruction.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of Certifier

29c. License number

D02026

29d. Date signed (Month, Day, Year)

Aug 7-99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEDERICO G. ARTHES, M.D. 46 TEAL CIRCLE OCEAN PINES MD 21811 410-641-4400

State
Registrar

31. Date filed (Month, Day, Year)

AUG 11 1999

32. Registrar's Signature

F. Sparks

MUNDY, MARGARET
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 26884

Reg. No.

| | | | | | | | | | | |
|--|---|---|---|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DORIS ELIZABETH MOORE | | | | | | 2. Date of Death Month August Day 7 Year 1999 | | 3. Time of Death 9:41 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) Genesis Elder Care Center, Spa Creek | | | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 579 26 0395 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 73 Yrs. | | 8. Date of Birth (Month, Day, Year) May 19, 1926 | | 9. Birthplace (State or Foreign Country) Wash., D.C. | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Lothian | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 5253 Ed Prout Road | | | | 10f. Zip Code 20711 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | | 16b. Kind of Business/Industry own home | | | |
| 17. Father's Name (First, Middle, Last) William Brack Honeycutt | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margie Elouise Knode | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Carolyn A. Trott/ daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1110 Upper Pindell Rd., Lothian, MD 20711 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Mem. Gardens | | Date 8-10-99 | | 20c. Location - City or Town, State Waldorf, MD | | |
| 21. Signature of Funeral Service Licensee  | | | | | | 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Parkinson's Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 13 years | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | | | 29c. License number D29193 | | 29d. Date signed (Month, Day, Year) 08/09/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Kilham MD, 180 Admiral Cochrane Drive, Annapolis, MD 21401-7366 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | 32. Registrar's Signature  | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.

I am sorry to hear that you are having trouble with your machine. I will try to get it fixed as soon as possible.

I am, Sir, very respectfully,
Your obedient servant,
J. H. Smith

I am, Sir, very respectfully,
Your obedient servant,
J. H. Smith

I am, Sir, very respectfully,
Your obedient servant,
J. H. Smith

I am, Sir, very respectfully,
Your obedient servant,
J. H. Smith

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26885

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Laurie Anne Newman | | | | 2. Date of Death Month Day Year AUGUST 15, 1999 | | 3. Time of Death 02:35 AM | |
| | 4a. Facility Name (If not institution, give street and number) WILLIAM BEANS ROAD AND FEDERAL COURT | | | | 4b. City, Town, or Location of Death Upper Marlboro | | 4c. County of Death PRINCE GEORGES | |
| Funeral Director | 5. Social Security Number 218-17-9324 | | 8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 18 Yrs. | | 6. Date of Birth (Month, Day, Year) June 6, 1981 | |
| | Usual Residence of Decedent | | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Shady Side | |
| 10e. Street and Number 1178 Grove Avenue | | 10f. Zip Code 20764 | | 10g. Citizen of What Country? USA | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | 16b. Kind of Business/Industry US Census Bureau | | | | |
| 17. Father's Name (First, Middle, Last) William A. Newman | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marianne Maroudas | | | | |
| 19a. Informant's Name/Relationship (Type, Print) William A. Newman/ Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1178 Grove Avenue Shady Side, Maryland 20764 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Meml. Gardens | | 20c. Location - City or Town, State 8-19-99 Davidsonville, MD | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cardiopulmonary asphyxia</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 8.15.99 | | 28b. Time of Injury 0225 M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred passenger ejected from vehicle that rolled over | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Wm Beans Rd. Federal A. Marlboro | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) AUGUST 15, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 17 1999 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

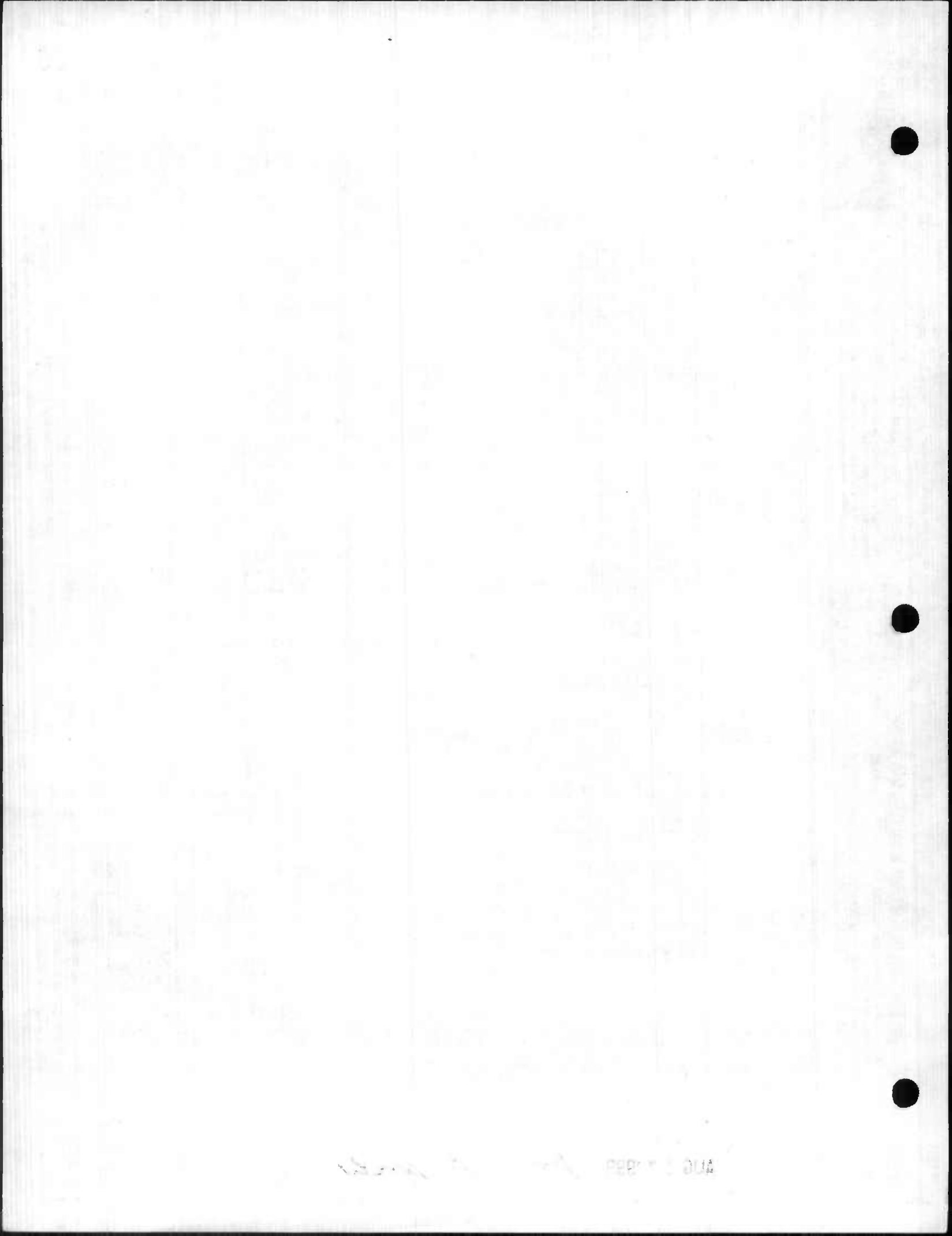
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

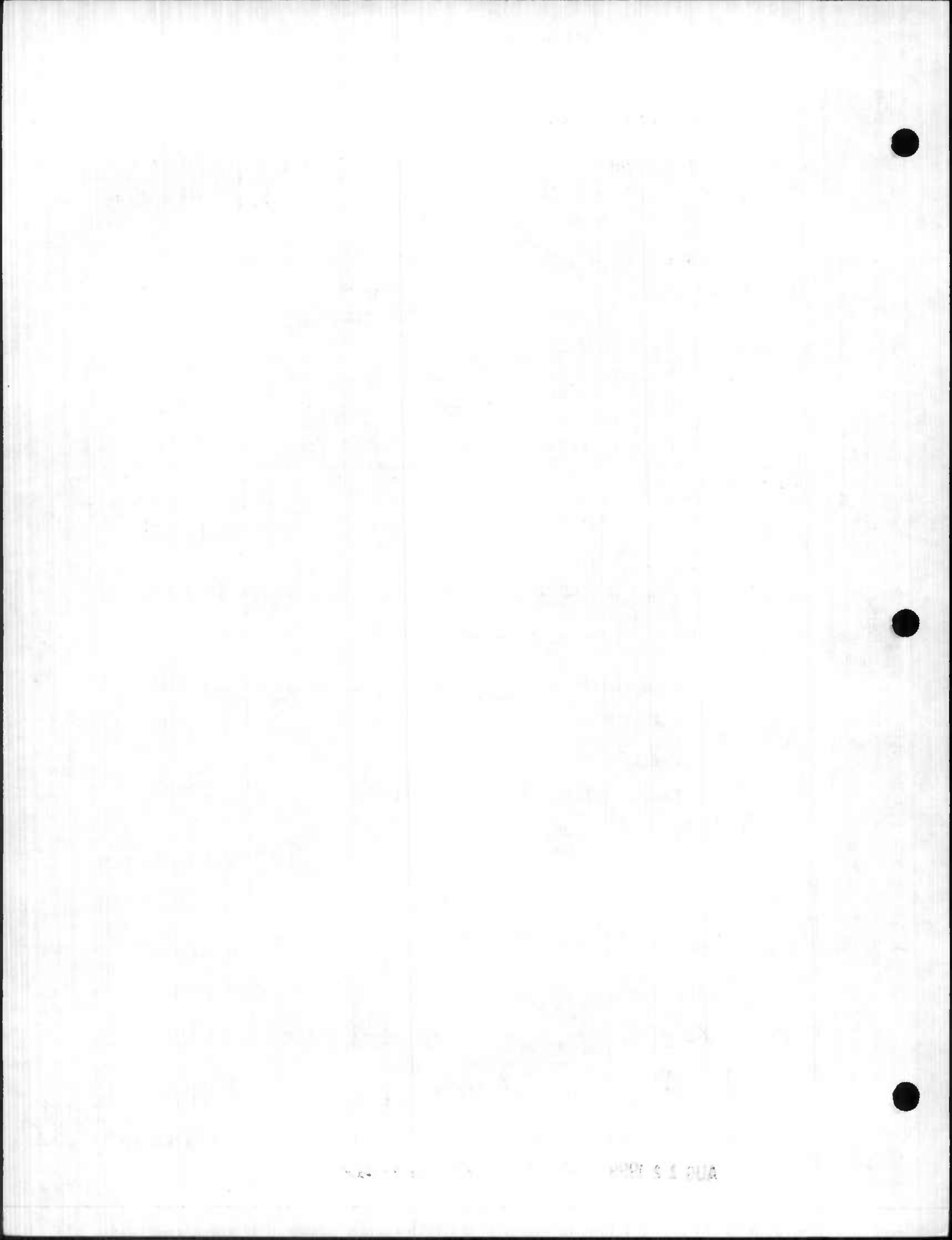
State of Maryland / Department of Health and Mental Hygiene

99 26886

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|-------------------------------|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James Francis O'Meara, Sr. | | | | 2. Date of Death Month Day Year August 11, 1999 | | | | 3. Time of Death 5:00 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) 424 Riverview Drive | | | | 4b. City, Town, or Location of Death Edgewater | | | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 577-18-0097 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 5, 1922 | | 9. Birthplace (State or Foreign Country) Washington, DC | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Edgewater | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 424 Riverview Drive | | | | 10f. Zip Code 21037 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: W.W. II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronics Mechanic | | | 16b. Kind of Business/Industry Federal Government | | |
| | 17. Father's Name (First, Middle, Last) Harry Dominic O'Meara | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Regina Glorius | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Jeannette L. O'Meara/ Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 424 Riverview Drive Edgewater, Maryland 21037 | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | Date 8-12-99 | | 20c. Location - City or Town, State Alexandria, VA | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Prostatic carcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| State Registrar | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier | | | | 29c. License number 019838 | | 29d. Date signed (Month, Day, Year) 8/11/99 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart E. Selonich, M.D. 900 Bestgate Annapolis, Md. 21401 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1999 | | 32. Registrar's Signature | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26887

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Rhonda E. LEEN Olcott | | | | 2. Date of Death Month July Day 21 Year 1999 | | | | 3. Time of Death 10:50pm | |
| | 4a. Facility Name (If not institution, give street and number) Mariner Health of Southern Maryland | | | | 4b. City, Town, or Location of Death Clinton | | | | 4c. County of Death Prince George | |
| Funeral Director | 5. Social Security Number 371-50-0461 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 49 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 2, 1949 | | 9. Birthplace (State or Foreign Country) Michigan | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Temple Hills | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 7502 Harrison Lane | | | | 10f. Zip Code 20748 | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bartender | | | | 16b. Kind of Business/Industry American Legion #248 | | |
| 17. Father's Name (First, Middle, Last) James Carl Doner | | | | 18. Mother's Name (First, Middle, Maiden Surname) Awanda Ione Doremire | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Stephen J. Olcott (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7502 Harrison Lane Temple Hills, Maryland 20748 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland State Veterans Cem. | | | | 20c. Location - City or Town, State Cheltenham Maryland | | |
| 21. Signature of Funeral Service Licensee [Signature] | | | | 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. METASTATIC CARCINOMA Due to (or as a consequence of): b. CARCINOMA OF LUNG Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate interval Between Onset and Death MORE THAN 1 MONTH MORE THAN 3 MONTHS | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier [Signature] | | | | 29c. License number D 50653 | | |
| | | | | 29d. Date signed (Month, Day, Year) 7-22-1999 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN CHAND SURANA 5851 DEALE CHURCHTON ROAD DEALE MD. 20751 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 23 1999 | | | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's development.

The second part of the report deals with the economic situation of the country. It is a very interesting and informative study of the country's economic development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's economic development.

The third part of the report deals with the social situation of the country. It is a very interesting and informative study of the country's social development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's social development.

The fourth part of the report deals with the political situation of the country. It is a very interesting and informative study of the country's political development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's political development.

The fifth part of the report deals with the cultural situation of the country. It is a very interesting and informative study of the country's cultural development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's cultural development.

The sixth part of the report deals with the environmental situation of the country. It is a very interesting and informative study of the country's environmental development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's environmental development.

The seventh part of the report deals with the international situation of the country. It is a very interesting and informative study of the country's international development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's international development.

The eighth part of the report deals with the future of the country. It is a very interesting and informative study of the country's future development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's future development.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Line # 5, 8/13/99
rjw, Cecil Co.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

99 26888

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nancy J. Pollock

2. Date of Death
Month Day Year

8 7 99

3. Time of Death

5:38pm

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin, MD

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

221-46-2486

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
8/16/55

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

DE

10b. County

New Castle

10c. City, Town or Location

newark

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

713 Cobble Creek Curve

10f. Zip Code

19702

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

James McAllister

18. Mother's Name (First, Middle, Maiden Surname)

Sally Ballard

19a. Informant's Name/Relationship (Type, Print)

Christopher W. Abrams / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

713 Cobble Creek Curve, Newark, DE 19702

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Philadelphia Crematories, Inc.

Date

8/13/99

20c. Location - City or Town, State

Philadelphia, PA

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Beeson Memorial Services
2053 Pulaski Hwy., Newark, DE 19702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracerebral Hemorrhage

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cerebral Edema

Due to (or as a consequence of):

3 hrs

c. Supratentorial Herniation

Due to (or as a consequence of):

3 hrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D0053612

29d. Date signed (Month, Day, Year)

8/8/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Andrea Hoffman MD 124 N. Main St. Berlin, MD 21811

31. Date filed (Month, Day, Year)

AUG 13 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, 790



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 26889**
Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|---|--|---|--|---|--|--|---|--|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GARY WAYNE PHIPPS, SR. | | | | 2. Date of Death Month Day Year AUGUST 13, 1999 | | | | 3. Time of Death 9:30 P.M. | | | |
| | 4a. Facility Name (If not institution, give street and number) GLADYS SPELLMAN SPECIALTY HOSPITAL | | | | 4b. City, Town, or Location of Death CHEVERLY | | | | 4c. County of Death PRINCE GEORGE | | | |
| Funeral Director | 5. Social Security Number 219-72-6214 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday) 41 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN. 8, 1958 | | 9. Birthplace (State or Foreign Country) VIRGINIA | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State MARYLAND | | | 10b. County PRINCE GEORGE | | | 10c. City, Town or Location CHEVERLY | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 1 HOSPITAL DRIVE | | | | | 10f. Zip Code 20785 | | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AUTO MECHANIC | | | 16b. Kind of Business/Industry AUTO PARTS STORE | | | | |
| 17. Father's Name (First, Middle, Last) GEORGE KLINE PHIPPS | | | | | 18. Mother's Name (First, Middle, Maiden Surname) RUTH FRANCES MATTHEW | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ODEN PHIPPS-BROTHER | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11064 DeMARR ROAD WHITE PLAINS, MD. 20695 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEM. GARDENS | | | Date 8-19-99 | | 20c. Location - City or Town, State WALDORF, MARYLAND | | |
| 21. Signature of Funeral Service Licensee  | | | | | 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Aneurysm Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death hour | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anoxic Encephalopathy | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | 29b. Signature and title of certifier  | | | 29c. License number D25099 | | 29d. Date signed (Month, Day, Year) 8-16-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don H. Yablonsky, M.D. 7404 Executive Place #502 Seabrook, MD 20706 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 17 1999 | | | | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26890

| | | | | | | | | | | |
|---|--|--|--|---|---|---------------------------------|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JACK POWERS | | | | 2. Date of Death Month Day Year 08/14/1999 | | | | 3. Time of Death 6:45 AM | |
| | 4a. Facility Name (If not institution, give street and number) SUNRISE CARE AND REHABILITATION | | | | 4b. City, Town, or Location of Death ELKTON | | | | 4c. County of Death CECIL | |
| Funeral Director | 5. Social Security Number 222-24-9826 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 69 Yrs. | | 8. Date of Birth (Month, Day, Year) 10/1/1929 | | 9. Birthplace (State or Foreign Country) DOVER, NJ | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State DELAWARE | | 10b. County NEW CASTLE | | 10c. City, Town or Location WILMINGTON | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 9 CATALPA AVENUE | | | | 10f. Zip Code 19804 | | | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 9/2/52-9/1/55 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHEMIST | | | | 16b. Kind of Business/Industry HERCULES, INC. | | |
| 17. Father's Name (First, Middle, Last) JACK POWERS | | | | 18. Mother's Name (First, Middle, Maiden Surname) MABEL WELSH | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JOHN VAN SYCKEL | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 GORDON ROAD, WHARTON, NJ 07885 | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) PHILADELPHIA CREMATORIES | | | | 20c. Location - City or Town, State 8/17/99 PHILADELPHIA, PA | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility BEESON MEMORIAL SERVICES 2053 PULASKI HIGHWAY, NEWARK, DE 19702 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Lung Disease Due to (or as a consequence of): Lung Mass Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Malnourishment | | | | | | | | Approximate Interval Between Onset and Death years 4 yrs | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnourishment | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number D23322 | | |
| 29d. Data signed (Month, Day, Year) 8-16-99 | | | | 29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sheelmohan S. Sachdev MD 118 North St, ELKTON, Md. 21921 | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 17 1999 | | | | 32. Registrar's Signature | | | | | | |

Handwritten signature and text: "Handwritten signature" and "PAGE 1 OF 2"

State of Maryland / Department of Health and Mental Hygiene 99 26891
Certificate of Death

Reg. No.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 26892**
Certificate of Death

Reg. No.

| | | | | | |
|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Virginia Sevilla Russell Bradley Paddy | | 2. Date of Death Month Aug Day 1 Year 1999 | | 3. Time of Death 3:20 AM |
| | 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death Prince George's |
| Funeral Director | 5. Social Security Number 578 18 1884 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) Jan 10, 1918 | | 9. Birthplace (State or Foreign Country) Washington DC | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County P.G. | | 10c. City, Town or Location Clinton | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 9106 Pineview Lane | | 10f. Zip Code 20735 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 5 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Own Home | |
| 17. Father's Name (First, Middle, Last) Clarence Myrton Russell | | 18. Mother's Name (First, Middle, Maiden Surname) Sevilla M. Foster | | | |
| 19a. Informant's Name/Relationship (Type, Print) Patricia Gibson (DAUGHTER) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3113 Parkway, Cheverly, Maryland 20785 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery Aug 5, 1999 | | 20c. Location - City or Town, State Washington, DC | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute myocardial infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death 4 days. |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DDDM sepsi | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D46478 | |
| 29d. Date signed (Month, Day, Year) 8-2-99 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh A. Patel M.D. 7501 Surratts Rd # 307, Clinton, MD 20735 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 03 1999 | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

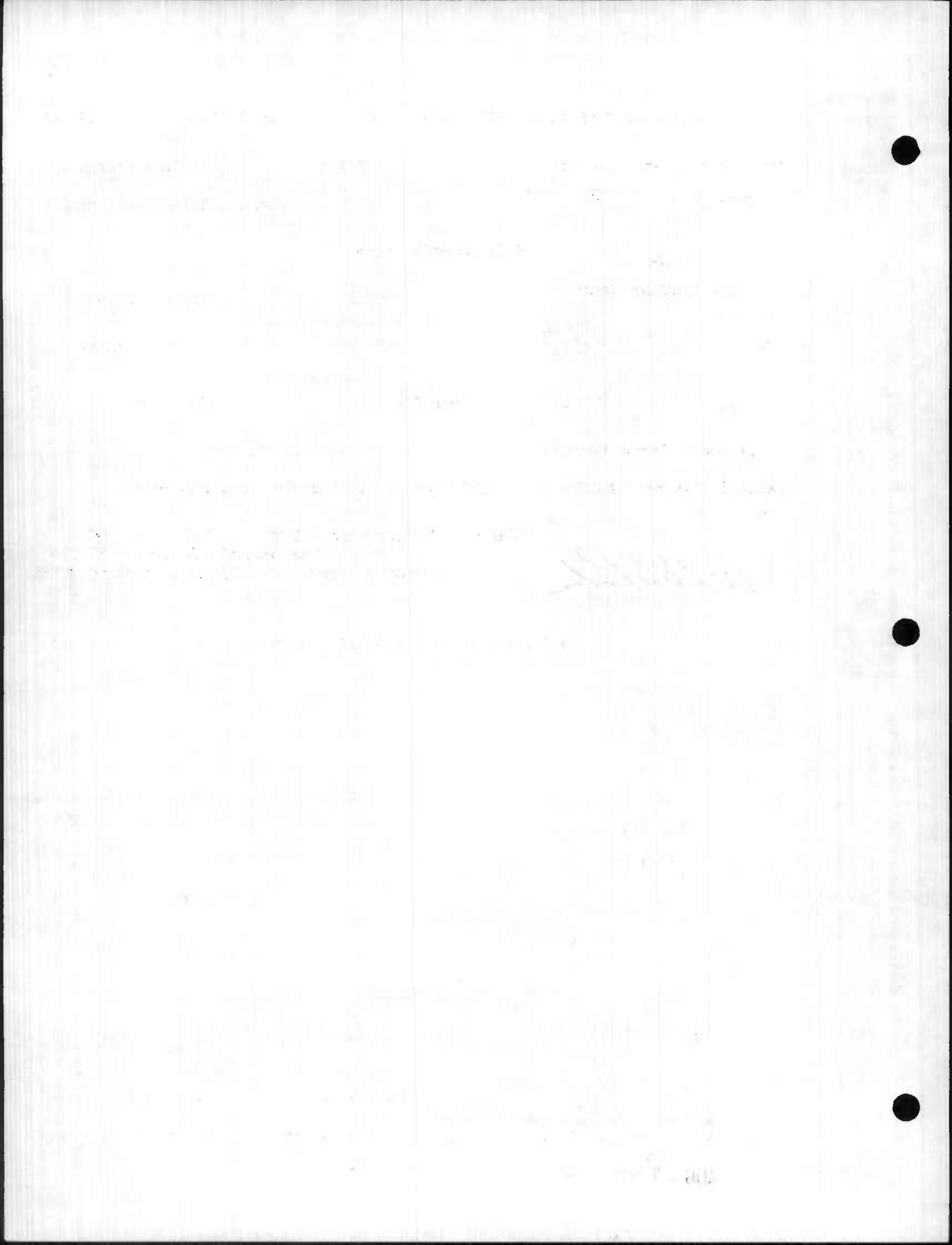
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26893

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|---------------------|---|---|--|---|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Esther Lee Pennington | | | | | | 2. Date of Death Month Day Year July 26, 1999 | | 3. Time of Death 9:15PM | | |
| | 4a. Facility Name (If not institution, give street and number) Bradford Oaks Nursing Home | | | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death Prince George | | | | |
| Funeral Director | 5. Social Security Number 578 12 5865 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) June 23, 1913 | | 9. Birthplace (State or Foreign Country) Washington, DC | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County P.G. | | 10c. City, Town or Location Camp Springs | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 5209 Kenstan Drive | | | | 10f. Zip Code 20748 | | 10g. Citizen of What Country? United States | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Travel Voucher Examiner | | | 16b. Kind of Business/Industry NOAA Federal Government | | | | |
| 17. Father's Name (First, Middle, Last) Edward Lee Keller | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Martha Lederer | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ruth Haydon (DAUGHTER) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5209 Kenstan Drive, Camp Springs, Maryland 20748 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cemetery | | 20c. Location - City or Town, State Adelphi, Maryland | | 20d. Date of Disposition July 30, 1999 | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death 2 hrs | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic cardiovascular disease | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Were an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number 19431 | | 29d. Date signed (Month, Day, Year) 7/27/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank M. Ryan, MD, 11701 Livingston Rd #205 FT. Washington MD 20744 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) 307 2 9 1000 | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26894

| | | | | | | | | |
|--|---|---|--|---|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary Gertrude QUILLEN | | | | 2. Date of Death Month Day Year August 02, 1999 | | 3. Time of Death 10:15 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) 1950 Kingswood Drive | | | | 4b. City, Town, or Location of Death Prince Frederick Calvert | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 207 20 2613 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 77 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov 9, 1921 | | 9. Birthplace (State or Foreign Country) Pennsylvania |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Calvert | | 10c. City, Town or Location Prince Frederick | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 1950 Kingswood Drive | | | | 10f. Zip Code 20678 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | 16b. Kind of Business/Industry own home | | |
| 17. Father's Name (First, Middle, Last) Michael McLaughlin | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ednell Passmore | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Michael J. Quillen | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as # 10 above | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Cemetary | | Date 8-3-99 | | 20c. Location - City or Town, State Alexandria, VA | | |
| 21. Signature of Funeral Service Licensee William R. Jones | | | | 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 | | | | |
| 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? Inspection <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Margarete Kurell | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) August 02, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature B. Jones | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26895

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS CLAUDE RHODES

2. Date of Death

Month Day Year
AUGUST 14, 1999

3. Time of Death

3:35PM

4a. Facility Name (If not institution, give street and number)

CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death

LAPLATA

4c. County of Death

CHARLES

Funeral
Director

5. Social Security Number

220-28-7321

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
August 11, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Indian Head

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

112 Charles Street

10f. Zip Code

20640

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1951-1960

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Staff Sergeant

16b. Kind of Business/Industry

National Guard

17. Father's Name (First, Middle, Last)

Lomax Byron Rhodes, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Helen Patricia Sprague

19a. Informant's Name/Relationship (Type, Print)

Renee Rhodes/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1707 Viewmont Drive, Los Angeles, California, 90069

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

August 17, 1999

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

William Williams

22. Name and Address of Facility

Williams Funeral Home, P.A.
4270 Hawthorne Road, Indian Head, Maryland 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Ischemic Heart Disease*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Status post Angioplasty 2/24/99

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Yahia M. Tagouri MD

29c. License number

D-50883

29d. Date signed (Month, Day, Year)

8-14-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

YAHIA M. TAGOURI, MD, ST. MARY'S HOSPITAL
DEPT OF PATHOLOGY 25500 PT LOOKOUT RD, LEONARDTOWN, MD 20650

31. Date filed (Month, Day, Year)

AUG 17 1999

32. Registrar's Signature

[Signature]

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Thomas C. Rhodes

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26896

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

State
Registrar

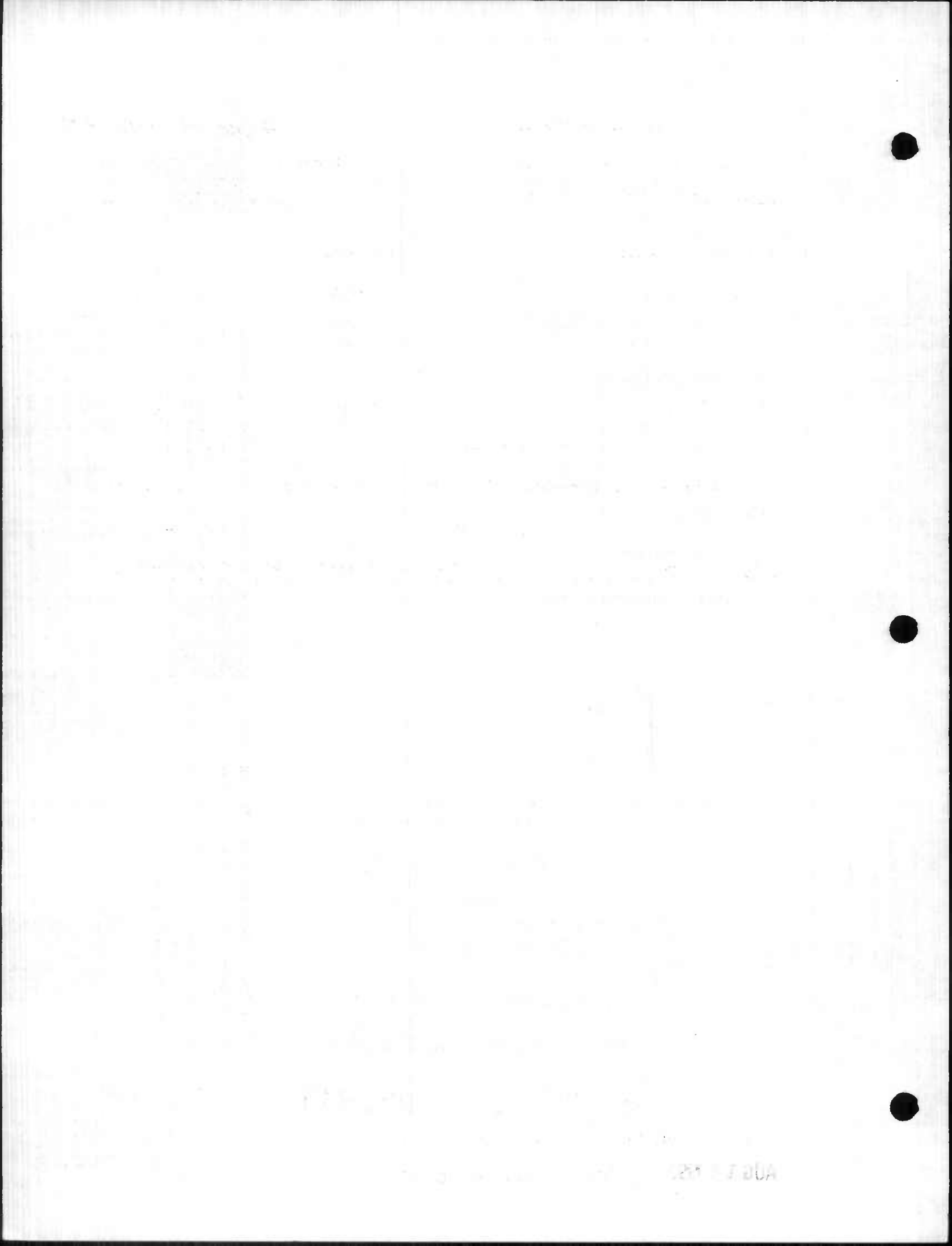
| | | | | | | | |
|--|--|---|---|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Barry Wade Richardson | | | | 2. Date of Death Month Day Year August 14 1999 | | 3. Time of Death 2140 | |
| 4a. Facility Name (If not institution, give street and number) Dorchester General Hospital | | | | 4b. City, Town, or Location of Death Cambridge | | 4c. County of Death Dorchester | |
| 5. Social Security Number 221-46-1823 | | 8. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/> | 7. Age (in yrs. last birthday) 38 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 19, 1961 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| 10a. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location Port Deposit | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 736 Principio Road | | | | 10f. Zip Code 21904 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Eleven Years College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Never Employed | | 16b. Kind of Business/Industry Never Employed | |
| 17. Father's Name (First, Middle, Last) Luther John Richardson, Jr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Linda Keesey | | | |
| 19a. Informant's Name/Relationship (Type, Print) Luther J. Richardson, Sr. (grandfather) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 736 Principio Road, Port Deposit, Maryland 21904 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mark's Cemetery | | Date 8/17/99 | | 20c. Location - City or Town, State Perryville, Maryland | |
| 21. Signature of Funeral Service Licensee Theresa M. Patterson, Sr. | | | | 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903-0188 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration PNEUMONIA. Due to (or as a consequence of): ULCERATIVE COLITIS. Due to (or as a consequence of): SEIZURE DISORDER. Due to (or as a consequence of): MENTAL RETARDATION. | | | | | | Approximate Interval Between Onset and Death Days. months years. years. | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ELECTROLYTE ABNORMALITY. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | 29c. License number P50 987 | | 29d. Date signed (Month, Day, Year) 8/15/99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ahmed Nawaz 105 Anwar street Cambridge MD | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 16 1999 | | | | 32. Registrar's Signature [Signature] 21613. | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26897

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Herbert Jerome Robinson | | | | 2. Date of Death Month Day Year August 7 99 | | 3. Time of Death 1825 | |
| | 4a. Facility Name (If not institution, give street and number) 130 Hearn Rd #503 | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death AA | |
| Funeral Director | 5. Social Security Number 191-22-3807 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 67 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 10, 1931 | |
| | 9. Birthplace (State or Foreign Country) Pennsylvania | | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Annapolis | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 130 Hearn Rd. Apt. 503 | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? US | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired | | 16b. Kind of Business/Industry Temple University Morgue | | | | |
| 17. Father's Name (First, Middle, Last) John Robinson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ella Mayo | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Marty Johnson (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1581 Ritchie Lane Annapolis, Md. 21401 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date 8-11-99 | | 20c. Location - City or Town, State Baltimore, Md. | | |
| 21. Signature of Funeral Service Licensee Larry A. Rose | | | | 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure UNK. Due to (or as a consequence of): b. Arteriosclerotic Heart Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. { | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier William P. Jones, MD Deputy | | 29c. License number D06054 | | 29d. Date signed (Month, Day, Year) 8/9/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jones, MD 695 Amorion 21035 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

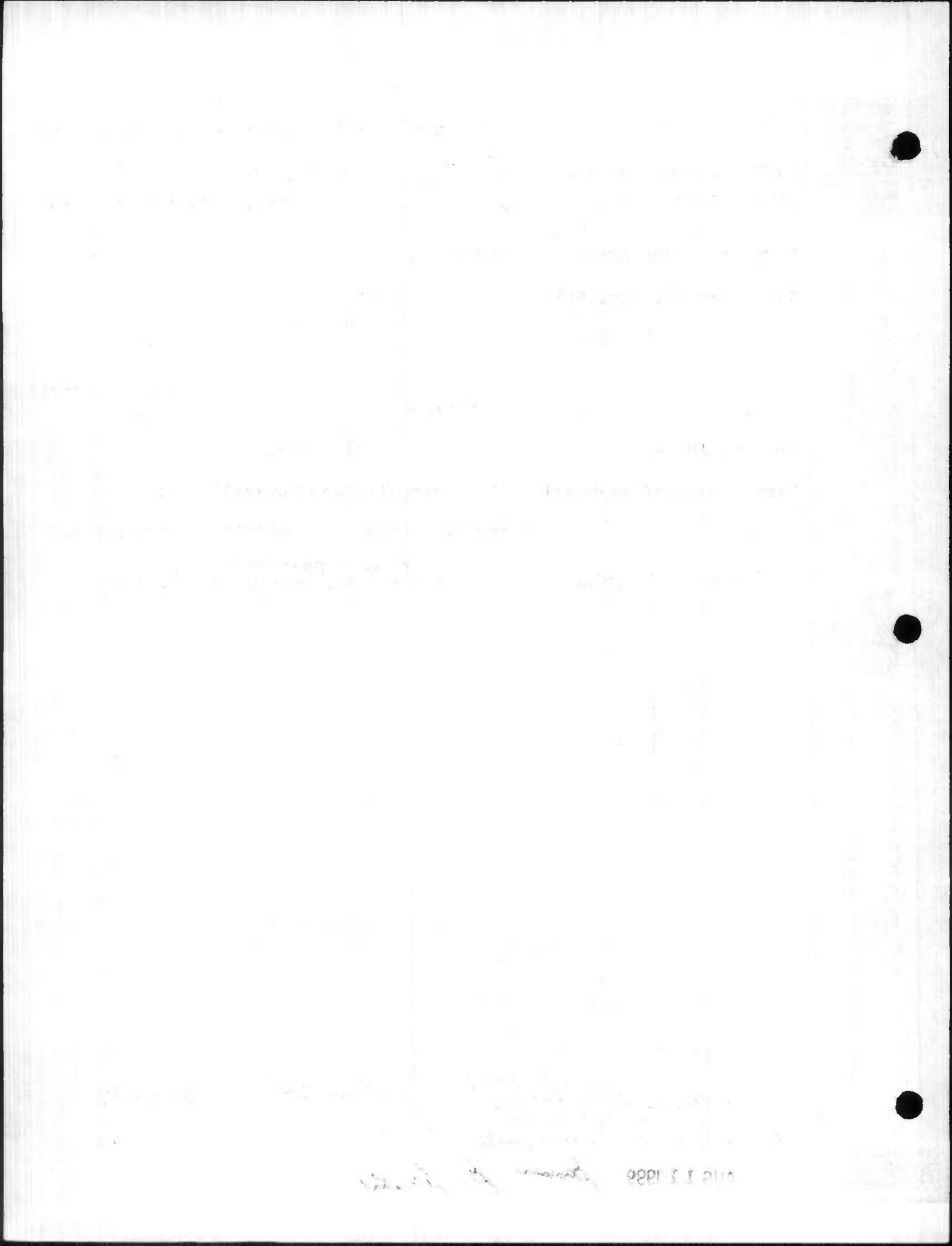
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 26899**
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Elena P. Rodriguez | | | | 2. Date of Death Month July Day 24 Year 1999 | | 3. Time of Death 11:10AM | |
| | 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Center | | | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 528-61-9803 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 69 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 19, 1930 | 9. Birthplace (State or Foreign Country) Philippines |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Cheltenham | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 10503 Westwood Drive | | | | 10f. Zip Code 20623 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify Filipino | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pharmasist | | 16b. Kind of Business/Industry Self-Employed | | |
| 17. Father's Name (First, Middle, Last) Mateo Pecson | | | | 18. Mother's Name (First, Middle, Maiden Sumame) Crescenciana Santos | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Imelda Miranda (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10503 Westwood Drive Cheltenham, Maryland 20623 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory | | Date July 26, 1999 | | 20c. Location - City or Town, State Clinton, Maryland |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) Uremia | | | | | | | | |
| Due to (or as a consequence of): Diabetes Mellitus | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Congestive Heart Failure Cerebrovascular Accident | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D30124 | | 29d. Date signed (Month, Day, Year) July 24, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew D. Howard M.D. 7801 Old Branch Avenue #202 Clinton, Maryland 20735-1687 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 29 1999 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26900

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) FRED ALEXANDER ROBERTS | | | | 2. Date of Death Month Day Year August 6, 1999 | | 3. Time of Death 03 40 | |
| | 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | |
| Funeral Director | 5. Social Security Number 214-12 5815 | | 6. Sex M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 91 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth Month Day Year 9/2/1907 | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Wicomico | | 10c. City, Town or Location Waterview Nursing Home | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number 105 Times Square | | | | 10f. Zip Code 21801 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waterman | | 16b. Kind of Business/Industry Oysterman | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) William B. Roberts | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Nutter | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Iona Townsend Granddaughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28206 Rockwalkin Ridge Rd, MD 21801 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Elsey Cemetery | | 20c. Location City or Town, State 8/13/99 Josterville, MD | | 20d. Zip Code 21801 | |
| | 21. Signature of Funeral Service Licensee Cornelius W. Smith | | 22. Name and Address of Facility Messick Funeral Home, P.O. Box 61 BIVILLE, MD 21814 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) a. ACUTE OR CHRONIC RESP FAILURE | | | | | | | | 48 HR. |
| Due to (or as a consequence of): b. ACUTE RENAL FAILURE | | | | | | | | 48 HR |
| Due to (or as a consequence of): c. | | | | | | | | |
| Due to (or as a consequence of): d. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCVD, PACEMAKER, CHF | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? N/A |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Danish Lund MD | | | | 29c. License number D32014 | | 29d. Date signed (Month, Day, Year) 8/6/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHESH MOINDRA MD 106 WILFORD ST SUITE 504B SALISBURY | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | 32. Registrar's Signature Danish A. Sparks MD 21814 | | | | | | |

114

10/1/20

115

10/2/20

10/1/20 10/2/20 10/3/20 10/4/20 10/5/20 10/6/20 10/7/20 10/8/20 10/9/20 10/10/20 10/11/20 10/12/20 10/13/20 10/14/20 10/15/20 10/16/20 10/17/20 10/18/20 10/19/20 10/20/20 10/21/20 10/22/20 10/23/20 10/24/20 10/25/20 10/26/20 10/27/20 10/28/20 10/29/20 10/30/20 10/31/20

10/1/20 10/2/20 10/3/20 10/4/20 10/5/20 10/6/20 10/7/20 10/8/20 10/9/20 10/10/20 10/11/20 10/12/20 10/13/20 10/14/20 10/15/20 10/16/20 10/17/20 10/18/20 10/19/20 10/20/20 10/21/20 10/22/20 10/23/20 10/24/20 10/25/20 10/26/20 10/27/20 10/28/20 10/29/20 10/30/20 10/31/20

10/1/20 10/2/20 10/3/20 10/4/20 10/5/20 10/6/20 10/7/20 10/8/20 10/9/20 10/10/20 10/11/20 10/12/20 10/13/20 10/14/20 10/15/20 10/16/20 10/17/20 10/18/20 10/19/20 10/20/20 10/21/20 10/22/20 10/23/20 10/24/20 10/25/20 10/26/20 10/27/20 10/28/20 10/29/20 10/30/20 10/31/20

10/1/20 10/2/20 10/3/20 10/4/20 10/5/20 10/6/20 10/7/20 10/8/20 10/9/20 10/10/20 10/11/20 10/12/20 10/13/20 10/14/20 10/15/20 10/16/20 10/17/20 10/18/20 10/19/20 10/20/20 10/21/20 10/22/20 10/23/20 10/24/20 10/25/20 10/26/20 10/27/20 10/28/20 10/29/20 10/30/20 10/31/20

10/1/20 10/2/20 10/3/20 10/4/20 10/5/20 10/6/20 10/7/20 10/8/20 10/9/20 10/10/20 10/11/20 10/12/20 10/13/20 10/14/20 10/15/20 10/16/20 10/17/20 10/18/20 10/19/20 10/20/20 10/21/20 10/22/20 10/23/20 10/24/20 10/25/20 10/26/20 10/27/20 10/28/20 10/29/20 10/30/20 10/31/20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26901

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|---|--|---|--|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CECELIA ALVATER Soulsby | | | | | | 2. Date of Death Month Day Year August 7, 1999 | | 3. Time of Death 8:50pm | | |
| | 4a. Facility Name (If not institution, give street and number) WILLIAM HILL MANOR | | | | | | 4b. City, Town, or Location of Death EASTON | | 4c. County of Death TALBOT | | |
| Funeral Director | 5. Social Security Number 213-24-2570 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN. 30, 1909 | | 9. Birthplace (State or Foreign Country) MARYLAND | | |
| | 10a. State MD | | 10b. County TALBOT | | 10c. City, Town or Location EASTON | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 10e. Street and Number 26245 TUNIS MILLS ROAD | | 10f. Zip Code 21601 | | 10g. Citizen of What Country? USA | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MEDICAL SECRETARY | | 16b. Kind of Business/Industry HEALTH | | | | | | | |
| 17. Father's Name (First, Middle, Last) WILLIAM JEWELL ALVATER | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) ELIZA L. PATTERSON | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) RICHARD H. STINSON/ SON | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4985 FRAZIER NECK ROAD, PRESTON, MD 21655 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CTR | | Date 8-11-99 | | 20c. Location - City or Town, State STEVENSVILLE, MD | | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> CSP | | | | | | 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Cerebral thrombosis Due to (or as a consequence of): b. Cerebral arteriosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death July 19, 1999 Uncertain | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. none | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Robert W. Trever, M.D. | | | | 29c. License number D10938 | | 29d. Date signed (Month, Day, Year) August 9, 1999 | |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print) ROBERT W. TREVER, M.D., 7696 OCEAN GATEWAY, EASTON, MD 21601 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 10 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

To Be Completed by Funeral Director

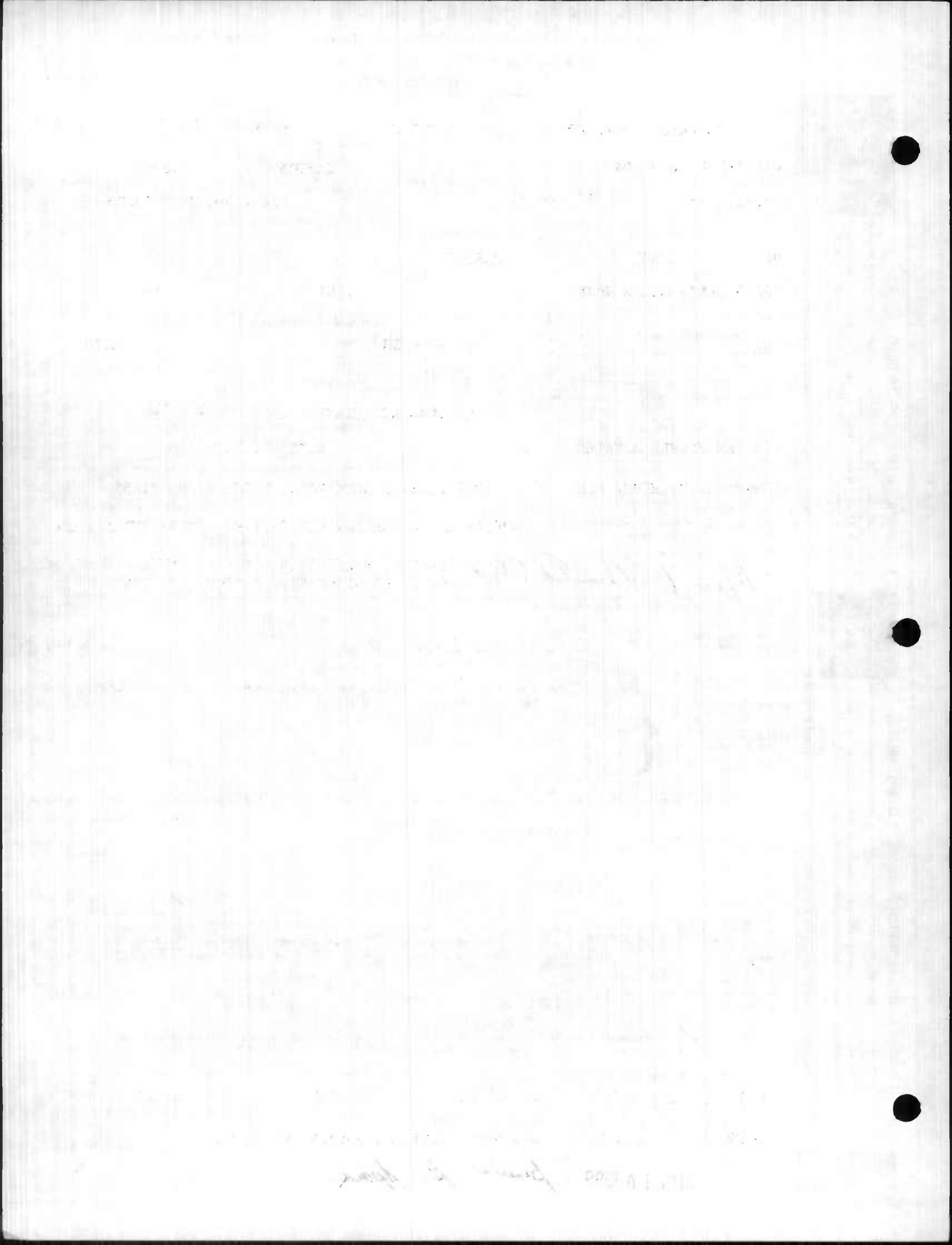
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26902

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

IRA TROY SPARROW

2. Date of Death

AUGUST 13 1999

3. Time of Death

8:20AM

4a. Facility Name (If not institution, give street and number)

CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death

LA PLATA

4c. County of Death

CHARLES

5. Social Security Number

230-30-5621

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 29, 1930

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

WALDORF

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3575 FOREST VIEW DRIVE

10f. Zip Code

20601

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OWNER/OPERATOR

16b. Kind of Business/Industry

CARPENTER

17. Father's Name (First, Middle, Last)

CHARLES DAY SPARROW

18. Mother's Name (First, Middle, Maiden Surname)

LUCY WIMBISH HYLER

19a. Informant's Name/Relationship (Type, Print)

BILLIE JOYCE SPARROW/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3575 FOREST VIEW DR., WALDORF, MD 20601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HIGHLAND BURIAL PARK

Date

8/17/1999 DANVILLE, VIRGINIA

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

JPK JOHN P. KNISLEY

MO1164

22. Name and Address of Facility

THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MARYLAND 20604-0156

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYELODYSPLASTIC SYNDROME

Due to (or as a consequence of):

b. SEPTIC SHOCK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

DR. KRISHAN MATHUR

29c. License number

D-28352

29d. Date signed (Month, Day, Year)

8/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRISHAN MATHUR M.D. 3500 OLD WASHINGTON ROAD SUITE 102 WALDORF MARYLAND 20602

31. Date filed (Month, Day, Year)

AUG 17 1999

32. Registrar's Signature

B. Sparks

State
Registrar

IRA SPARROW

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

Steven Edward
Smith Sr.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

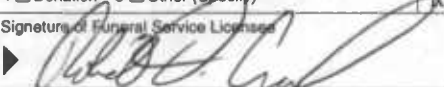
State of Maryland / Department of Health and Mental Hygiene

99 WK.

Certificate of Death

99 26903

Reg. No.

| | | | | | | | | | | | |
|---|---|---|--|---|---|---|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) STEVE EDWARD SMITH | | | | 2. Date of Death Month Day Year August 06 1999 | | | | 3. Time of Death 01:30 PM. | | |
| | 4a. Facility Name (If not institution, give street and number) Union Hospital | | | | 4b. City, Town, or Location of Death Elkton | | | | 4c. County of Death Cecil | | |
| Funeral Director | 5. Social Security Number 212-62-8166 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 44 Yrs. | | 8. Date of Birth (Month, Day, Year) January 6, 1955 | | 9. Birthplace (State or Foreign Country) Virginia | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location Elkton | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 161 Arbutus Street | | | | 10f. Zip Code 21921 | | | | 10g. Citizen of What Country? United States | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Operator Food Truck | | | | 16b. Kind of Business/Industry On-site food delivery Job-site delivery | | | |
| 17. Father's Name (First, Middle, Last) Vernon Smith | | | | 18. Mother's Name (First, Middle, Maiden Surname) Kathleen Justis | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Christine Lynn Smith / Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 161 Arbutus Street, Elkton, MD 21921 | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris Crematory | | Date Aug. 9 1999 | | 20c. Location - City or Town, State West Chester Pennsylvania | | | | | |
| 21. Signature of Funeral Service Licensed  | | | | 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, MD 21901 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIAC ARRHYTHMIA IN ASSOCIATION WITH PULMONARY THROMBOEMBOLIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier  Joseph Pestaner, M.D. | | | | 29c. License number O.C.M.E. | | | | 29d. Date signed (Month, Day, Year) August 8, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | | | 32. Registrar's Signature  B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 33a or 33a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26904

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RALPH L. SPOTTS

2. Date of Death
Month Day Year

8 15 99 8-30 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

737 DOCTOR MILLER RD.

4b. City, Town, or Location of Death

NORTH EAST

4c. County of Death

CECIL

5. Social Security Number

162-28-0084

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

FEBRUARY 7, 1933 JEWERSVILLE, PA.

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MD.

10b. County

CECIL

10c. City, Town or Location

NORTH EAST

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

737 DOCTOR MILLER RD.

10f. Zip Code

21901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

UNKNOWN

UNKNOWN

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SANITARIAN

16b. Kind of Business/Industry

COUNTY HEALTH DEPT.

17. Father's Name (First, Middle, Last)

WILBUR M. SPOTTS

18. Mother's Name (First, Middle, Maiden Surname)

AIDA JOHNSON

19a. Informant's Name/Relationship (Type, Print)

LENA I. SPOTTS - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

737 DOCTOR MILLER RD NORTH EAST, MD 21901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BRKK FRIENDS

Date

8/18/99 RISING SUN, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

RUFFENACH FUNERAL HOME 224 PENN AVE OXFORD, PA 17363

23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Colon Cancer

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► Ronald L. Linn MD

29c. License number

33099

29d. Date signed (Month, Day, Year)

8/17/99.

30. Name and address of person who completed cause of death (Item 25e) (Type, Print)

138 Calhoun Street GIBSON MD 21021

31. Date filed (Month, Day, Year)

AUG 17 1999

32. Registrar's Signature

B. Spotts

State
Registrar

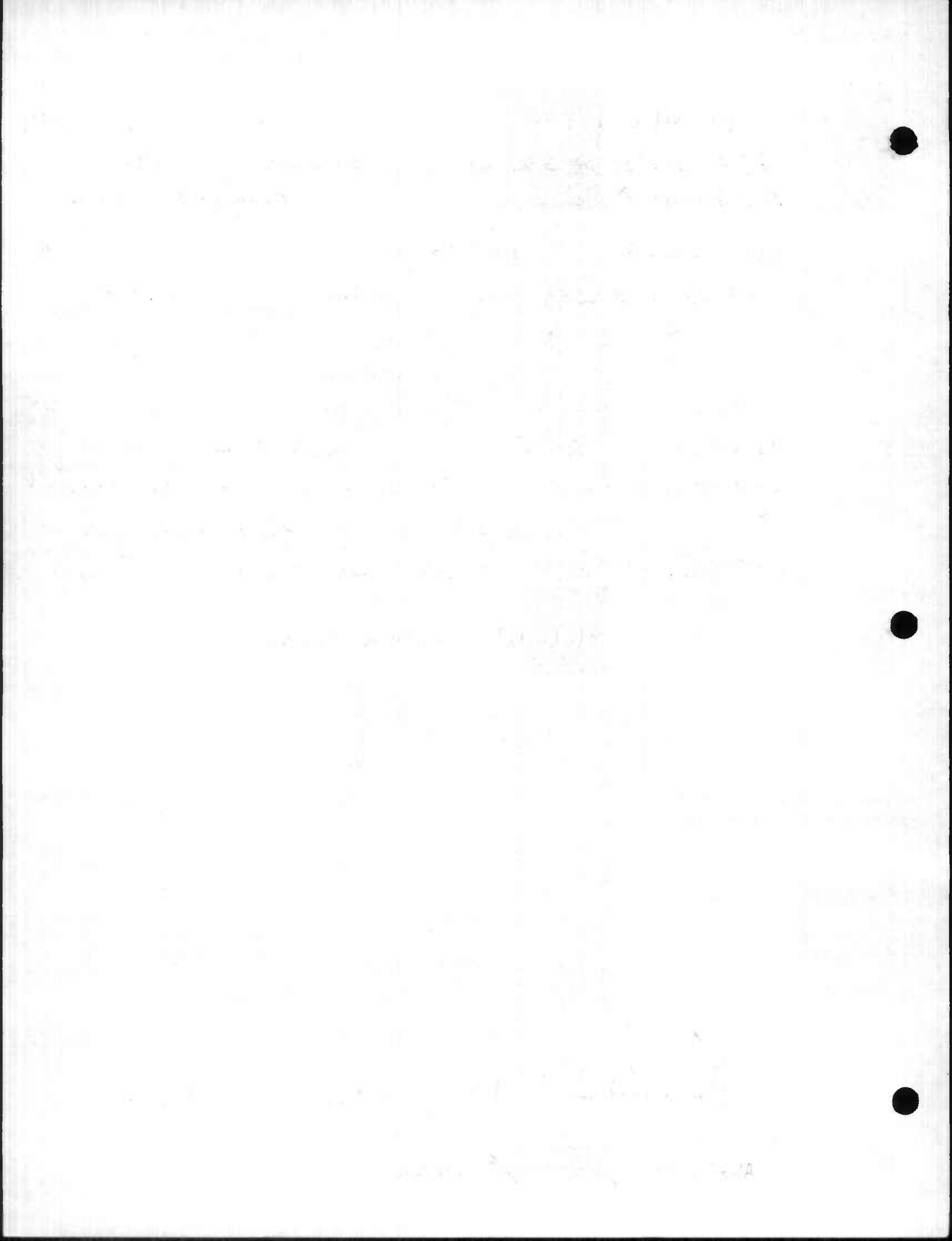
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26905

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|----------------------------|---|----------------------------------|-------------------------------------|----------------------------------|----|----------------------------------|--|----|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Christine Smith | | 2. Date of Death Month Aug Day 9 Year 1999 | | 3. Time of Death 6:00AM | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 1336 Marlboro Rd. | | 4b. City, Town, or Location of Death Lothian | | 4c. County of Death Anne Arundel | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 220-16-4694 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | | | | | | | | | | | | |
| | 8. Date of Birth (Month, Day, Year) May. 28, 1912 | | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Lothian | | | | | | | | | | | | | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 10e. Street and Number 1336 Marlboro Rd. | | | 10f. Zip Code 20711 | | 10g. Citizen of What Country? US | | | | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | | | | | | | | | | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic Worker | | 16b. Kind of Business/Industry Homemaker | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) James Franklin | | | 18. Mother's Name (First, Middle, Maiden Surname) Pauline Franklin | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Agnes Johnson (Niece) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1328 Marlboro Rd. Lothian, Md. 20711 | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Moses | | 20c. Location - City or Town, State 8-13-99 Lothian, Md. | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee Larry H. Reese | | | 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. multiple myeloma</td> <td rowspan="4"> Approximate Interval Between Onset and Death 6.5 years 7 months </td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. gastrointestinal bleeding</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c. </td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. </td> <td></td> <td></td> </tr> </table> | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. multiple myeloma | Approximate Interval Between Onset and Death 6.5 years 7 months | Due to (or as a consequence of): | b. gastrointestinal bleeding | Due to (or as a consequence of): | c. | Due to (or as a consequence of): | | d. | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. multiple myeloma | Approximate Interval Between Onset and Death 6.5 years 7 months | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | |
| | b. gastrointestinal bleeding | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | |
| c. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dementia | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | | | | | | | | | | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Jeanine Werner, MD | | 29c. License number D52830 | | 29d. Date signed (Month, Day, Year) August 9, 1999 | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jeanine Werner, 900 Bestgate Rd, Annapolis, MD 21401 | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | 32. Registrar's Signature Bruce B. Sparks | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

W. H. H. H.

Aug 11 1962

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26906

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carol M Smith

2. Date of Death

August 4 1999

3. Time of Death

17:30

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Systems

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

216-42-2610

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jun. 21, 1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland Anne Arundel

10b. County

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1406 Hayes Rd.

10f. Zip Code

21401

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (14 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic Worker

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Harry Hayes

18. Mother's Name (First, Middle, Maiden Surname)

Margie Maynard

19a. Informant's Name/Relationship (Type, Print)

Laura Smith (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1406 Hayes Rd. Annapolis, Md. 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Calvary Church Ceme. 8-12-99 Arnold, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Larry S. Reese

22. Name and Address of Facility

Wm. Reese & Sons Mortuary, P.A.
821 West St. Annapolis, Md. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coagulopathy, Hemorrhage

Due to (or as a consequence of):

b. Cholestatic Hepatitis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark M. Saba

29c. License number

3524

29d. Date signed (Month, Day, Year)

August 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK SABA 22 South Greene St Baltimore Maryland

State
Registrar

31. Date filed (Month, Day, Year)

AUG 11 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26907

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Beverly O'Bryant Scott

2. Date of Death

JULY 24 1999

3. Time of Death

10:30 P.M.

4a. Facility Name (If not institution, give street and number)

CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death

LAPLATA

4c. County of Death

CHARLES

Funeral
Director

5. Social Security Number

577-26-6324

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 28, 1923

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

2235 Wakefield Circle

10f. Zip Code

20602

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

William Edgar Murphy

18. Mother's Name (First, Middle, Maiden Surname)

Alice Newell Stone

19a. Informant's Name/Relationship (Type, Print)

Patricia A. King (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6571 Prairie Dog Ct. Waldorf, MD 20603

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

July 28th

1999

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, Inc.

6633 Old Alexandria Ferry Rd Clinton, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

20735

Immediate Cause (Final disease or condition resulting in death)

a. CANCER OF PANCREAS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

K. Mathur

29c. License number

D-28352

29d. Date signed (Month, Day, Year)

7/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRISHAN M MATHUR MD CAMBRIDGE PROF. CENTER SUITE # 102 WALDORF, MD 20602

31. Date filed (Month, Day, Year)

JUL 26 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Page 1

Very respectfully,
[Signature]

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26908

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Edith Smith

2. Date of Death

Month
JulyDay
30Year
1999

3. Time of Death

9:25pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

5. Social Security Number

578-34-9537

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

August 28, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Newburg

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

14740 South Cuckold Creek Road

10f. Zip Code

20664

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ACCOUNTING CLERK

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

John Maurice Smallwood

18. Mother's Name (First, Middle, Maiden Surname)

Eliza Marie Hill

19a. Informant's Name/Relationship (Type, Print)

Robertino M. Smoth

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20664
14740 South Cuckold Creek Road, Newburg, Maryland

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Ghost Catholic Cemetery

Date

8-5-99

20c. Location - City or Town, State

Newburg, Maryland

21. Signature of Funeral Service Licensee

Robert M. Smoth

22. Name and Address of Facility

Sterling Funeral Service
1601 Kenilworth Avenue, N.E., Washington, DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEPSIS

a. Due to (or as a consequence of):

SEVERE DEHYDRATION

b. Due to (or as a consequence of):

ACUTE MYOCARDIAL INFARCT

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kevin K. Lee, MD

29c. License number

D054804

29d. Date signed (Month, Day, Year)

07/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kevin K. Lee, MD Cenna Medical Center, 7C Post Office Rd. Waldorf, MD 20602

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

Diana G. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

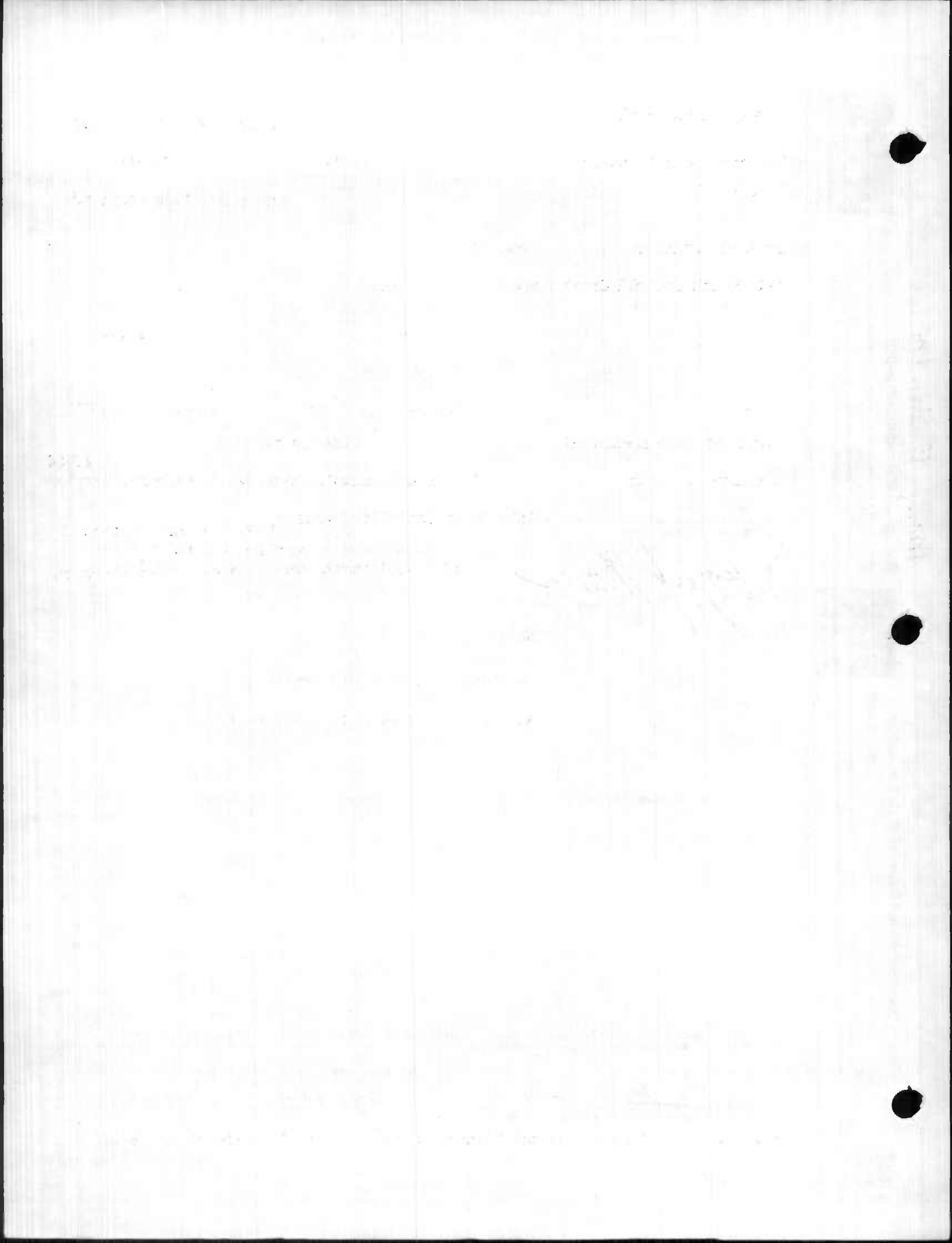
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MARY E Smith

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26909

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE THOMAS

STARKEY JR.

2. Date of Death

Month Day Year
JULY 31, 1999

3. Time of Death

1040 am

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

212 38 8080

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 5, 1938

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Sunderland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6830 Den-Mar Lane

10f. Zip Code

20689

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1956-76

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

project manager

16b. Kind of Business/Industry

computer

17. Father's Name (First, Middle, Last)

George Thomas Starkey, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Jennie Matson Martroni

19a. Informant's Name/Relationship (Type, Print)

Elizabeth C. Starkey/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as 10 above

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

8-3-99

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rausch Funeral Home, Owings, MD 20736

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Serratia Sepsis

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. Glioblastoma Multiforme

Due to (or as a consequence of):

d. Neutropenia

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D52192

29d. Date signed (Month, Day, Year)

July 31 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JULIE A. OKEEFE, M.D., PRINCE FREDERICK, MD 20678

31. Date filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26910

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HELEN JEAN STEVENSON | | | | 2. Date of Death Month Day Year AUG. 4 1999 | | 3. Time of Death 8:10 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number) 14574 FOLTZ DR. | | | | 4b. City, Town, or Location of Death EDEN | | 4c. County of Death SOMERSET | | |
| Funeral Director | 5. Social Security Number 213-24-1371 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) MAY 2, 1927 | | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MD | | 10b. County WICOMICO | | 10c. City, Town or Location SALISBURY | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 1514 RIVERSIDE DR. APT. 115 A | | 10f. Zip Code 21801 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 | | College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | | | |
| 17. Father's Name (First, Middle, Last) WILBUR ADAMS | | | | 18. Mother's Name (First, Middle, Maiden Surname) NELLIE JENKINS | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MORRIS T. STEVENSON, JR.-SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5963 RIDGESPRING CIRCLE SALISBURY, MD 21801 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) OLIVET CEMETERY | | Date 8-9-99 | | 20c. Location - City or Town, State EDEN, MD | | | |
| 21. Signature of Funeral Service Licensee B. Keitt Phypers CFSP | | | | 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pancreatic Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last COPD Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 3mo | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) DAUGHTER'S HOME | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | 29c. License number H50497 | | 29d. Date signed (Month, Day, Year) 8/5/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTOPHER SNYDER, M.D. 106 MILFORD ST., SUITE 201 SALISBURY, MD 21804 | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year) AUG 05 1999 | | 32. Registrar's Signature [Signature] | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3
uk

Handwritten signature and date: *John P. Smith* AUG 2 1953

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26911

Certificate of Death

Reg. No.

| | | | | | |
|---|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DONALD E. SPECK | | 2. Date of Death Month 8 Day 9 Year 99 | | 3. Time of Death 2030 |
| | 4e. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO |
| Funeral Director | 5. Social Security Number 210-24-8833 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 67 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) APRIL 27, 1932 | | 9. Birthplace (State or Foreign Country) PENNSYLVANIA | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State DELAWARE | | 10b. County SUSSEX |
| | 10c. City, Town or Location SELBYVILLE | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 231 W. POND CIRCLE | | 10f. Zip Code 19975 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-53 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER |
| | 17. Father's Name (First, Middle, Last) C. LEX SPECK | | 16b. Kind of Business/Industry EDUCATION | | 16. Mother's Name (First, Middle, Maiden Surname) THELMA A. HILEMAN |
| | 19a. Informant's Name/Relationship (Type, Print) THOMAS C. SPECK/BROTHER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 200, MILLCREEK, PENNSYLVANIA 17060 | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) RIVERVIEW CEMETERY | | 20c. Location - City or Town, State 8/17/99 HUNTINGDON, PA |
| | 21. Signature of Funeral Service Licensee <i>Cheryl W. Blantz</i> | | 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Asystole</i> Due to (or as a consequence of): b. <i>Acute myocardial infarction</i> Due to (or as a consequence of): c. <i>atherosclerotic heart disease</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cardiogenic shock</i> <i>ischemic cardiomyopathy</i> | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Cheryl W. Blantz</i> | | 29c. License number 19289 | |
| 29d. Date signed (Month, Day, Year) 8/9/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Cheryl W. Blantz</i> 400 Eastern Shore Dr Salisbury MD 21801 | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1999 | | 32. Registrar's Signature <i>Brenda B. Sparks</i> | | | |

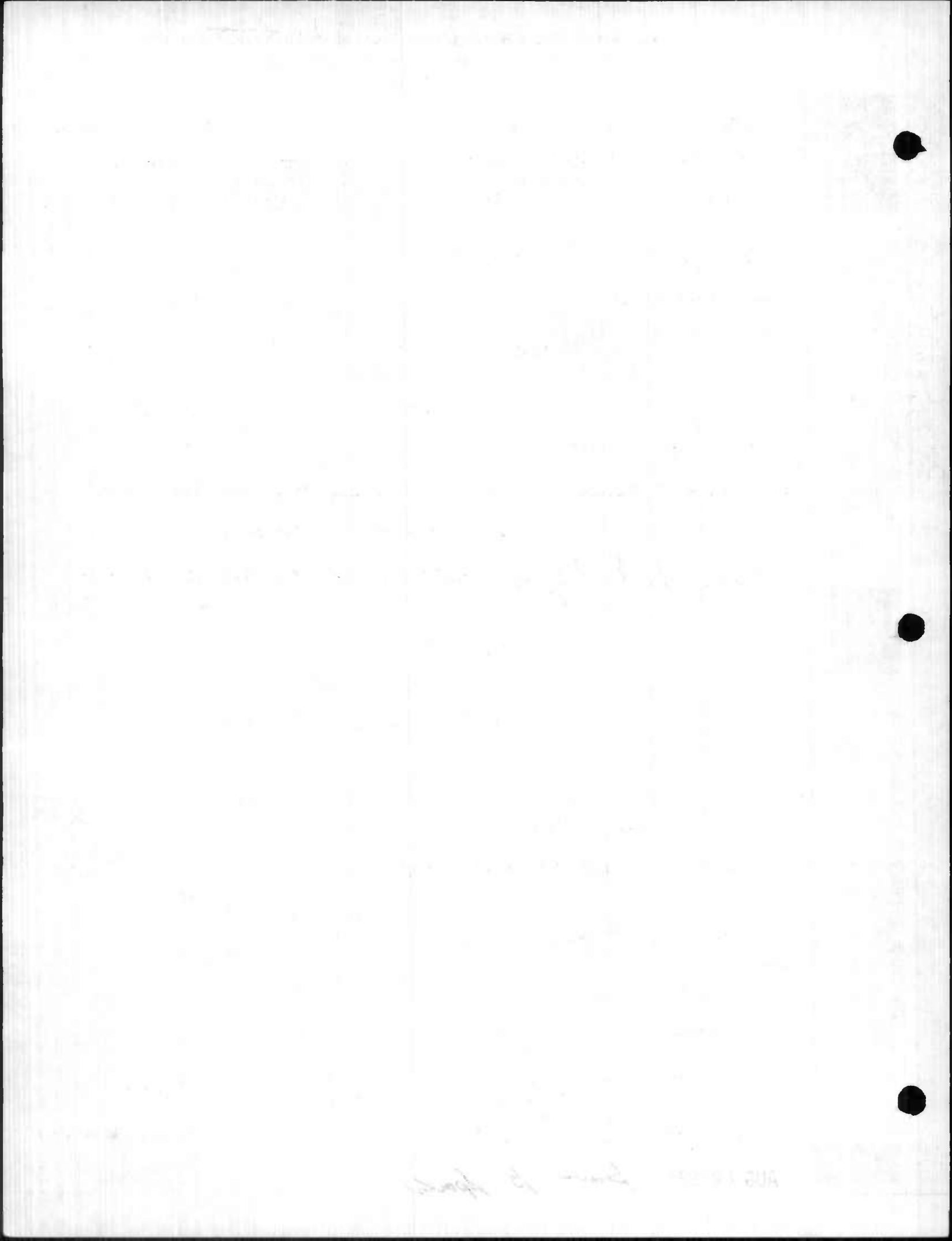
Donald Speck
210 24 8833
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,


To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



VOID

CERTIFICATE 

26912

SEE

CERTIFICATE 

26909

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26913

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Dorothy Cofer Staples | | | 2. Date of Death Month Day Year May 3, 1999 | | 3. Time of Death 6:15 PM | | | |
| | 4a. Facility Name (If not institution, give street and number) Holy Cross Rehabilitation Center | | | 4b. City, Town, or Location of Death Burtonsville | | 4c. County of Death Montgomery | | | |
| Funeral Director | 5. Social Security Number 224-09-4681 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 96 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Aug. 20, 1902 | 9. Birthplace (State or Foreign Country) VIRGINIA | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State VA | | 10b. County | | 10c. City, Town or Location Lynchburg | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 113 Middleboro Place | | | | 10f. Zip Code 24502 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SEAMSTRESS | | | 16b. Kind of Business/Industry BLUE BUCKLE OVERALL COMPANY | | |
| 17. Father's Name (First, Middle, Last) WILLIAM BURKS COFER | | | | | 18. Mother's Name (First, Middle, Maiden Surname) BERTA PREAS | | | | |
| 19a. Informant's Name/Relationship (Type, Print) GARY STAPLES (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1731 S.W. 72ND. AVENUE - PLANTATION, FLORIDA 33317 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) SPRINGHILL CEMETERY | | Date 5/6/99 | | 20c. Location - City or Town, State LYNCHBURG, VIRGINIA | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Renal Failure Due to (or as a consequence of): Liver Failure Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 3 Weeks | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depression, Dementia, TIA | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number 000053528 | | 29d. Date signed (Month, Day, Year) May 5, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daphna Henkin, MD 2309 Shorefield Road Wheaton, MD 20902 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 07 1999 | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Do Not copy
until Item
23A has been
completed
STAP/25
2
Georgie

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26914
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **Serafina F. "Sadie" Thomas**
2. Date of Death Month **August** Day **11** Year **1999** 3. Time of Death **1430**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **Union Hospital** 4b. City, Town, or Location of Death **Elkton, MD** 4c. County of Death **Cecil County**

5. Social Security Number **200-16-0396** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **74** Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **10/30/1924** 9. Birthplace (State or Foreign Country) **Dunmore, PA**

Usual Residence of Decedent 10a. State **MD** 10b. County **Cecil** 10c. City, Town or Location **Elkton** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **105 Hearthstone Drive, Heritage Woods** 10f. Zip Code **21921** 10g. Citizen of What Country? **USA**

11. Marital Status ☐ Navar Married ☒ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **1 yr.** Collage (1-4 or 5+) **Claim Clerk** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Railroad** 16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last) **Anthony Ferrese, Sr.** 18. Mother's Name (First, Middle, Maiden Surname) **Rose Serra**

19a. Informant's Name/Relationship (Type, Print) **Elmer Thomas/Husband** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **105 Hearthstone Dr., Elkton, MD 21921**

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Silverbrook Crematory** Date **8/13/99** 20c. Location - City or Town, State **Wilmington, DE**

21. Signature of Funeral Service Licensee **Frank C. Mayer, Jr.** 22. Name and Address of Facility **Spicer Mullikin Funeral Home 1000 N. DuPont Hwy., New Castle, DE 19720**

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Chronic Congestive Heart Failure 5 years**

Due to (or as a consequence of): **2° to Ischemic Dilated Cardiomyopathy 5 years**

Due to (or as a consequence of): **& Hypertensive Cardiovascular Disease 10 years**

Due to (or as a consequence of): **Interstitial Fibrosis of Lung 2 years**

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. **Diabetes Mellitus**

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 28. Place of Death (Check only one) Hospital: ☐ Inpatient ☒ Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicida ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **Jayantilal K Patel MD** 29c. License number **D22307** 29d. Date signed (Month, Day, Year) **8/12/99**

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) **JAYANTILAL K PATEL MD 123 Singlerly Ave, ELKTON, MD 21921**

31. Date filed (Month, Day, Year) **AUG 13 1999** 32. Registrar's Signature **P. Sparks**

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,


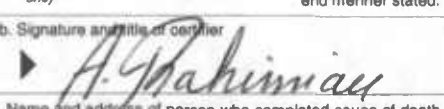
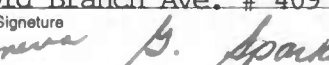
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26915

| | | | | | | | | | |
|--|--|--|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) George M. Tayman | | | | 2. Date of Death Month Day Year July 24, 1999 | | 3. Time of Death 4:45AM | | |
| | 4a. Facility Name (If not institution, give street and number) 7906 Colonial Lane | | | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death Prince George's | | |
| Funeral Director | 5. Social Security Number 578-40-8648 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 69 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 25, 1930 | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Clinton | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 7900 Old Alexandria Ferry Road | | | | 10f. Zip Code 20735 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter | | | 16b. Kind of Business/Industry George Tayman & Sons. Company | | |
| 17. Father's Name (First, Middle, Last) Jenkins N. Tayman | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Julie Lowe | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Kenneth L. Tayman (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7906 Colonial Lane Clinton, Maryland 20735 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery | | | 20c. Location - City or Town, State Clinton, Maryland | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Malignancy unknown primary Due to (or as a consequence of): b. Pericardial effusion Due to (or as a consequence of): c. pleural effusion Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Son's Residence | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29c. Signature and Title of Certifier  | | | | 29d. License number MD D0052949 | | 29e. Date signed (Month, Day, Year) 7/26/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ali Rahimian, M.D. 7801 Old Branch Ave. # 409 Clinton, Md. 20735 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 26 1999 | | | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

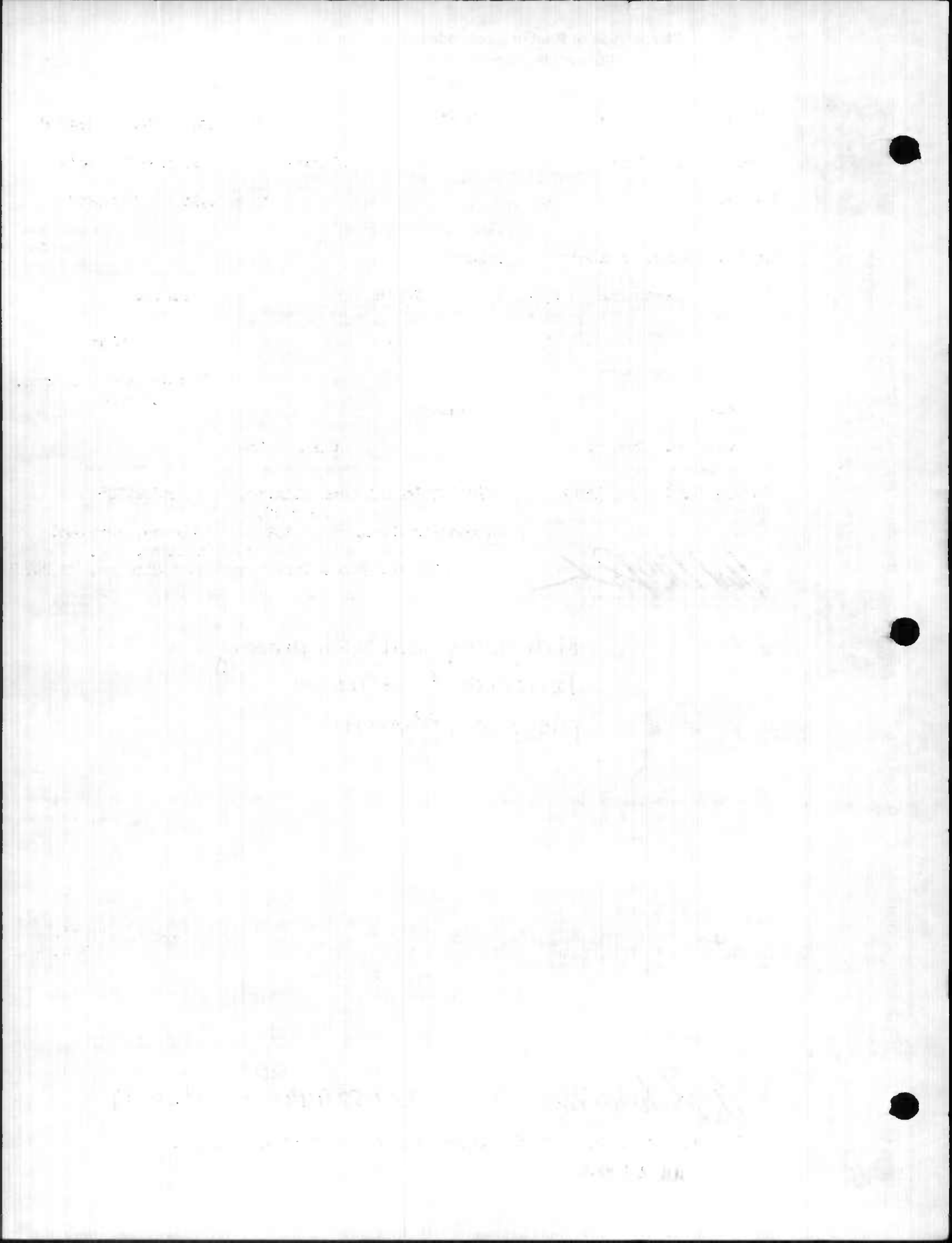
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

15

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26916

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|----------------------------|---|---|--|--|--|--|
| Physician (Medical Examiner) | 1. Decedent's Name (First, Middle, Last) Marguerite P. Trainor | | | | 2. Date of Death Month Day Year July 26, 1999 | | 3. Time of Death 8:45 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 9518 White Pillar Terrace | | | | 4b. City, Town, or Location of Death Gaithersburg | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 109 24 9532 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F XX | 7. Age (In yrs. last birthday) 68 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 1, 1931 | 9. Birthplace (State or Foreign Country) New York |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County P.G. | | 10c. City, Town or Location Forestville | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 2616 Newglen Ave | | | | 10f. Zip Code 20747 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager | | 16b. Kind of Business/Industry Prince George Community College | | |
| 17. Father's Name (First, Middle, Last) Richard I Burns | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marguerite Williams | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Dawn Trainor-Fogleman (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9518 White Pillar Terrace, Gaithersburg, MD 20882 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory July 30, 1999 | | 20c. Location - City or Town, State Clinton, Maryland | | |
| 21. Signature of Funeral Service Licensee St. G. Sitt | | | | 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiopulmonary Arrest Due to (or as a consequence of): b. Metastatic Parathyroid Gland Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Home Daughters | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier William S. Syloca MD | | 29c. License number Colorado 27148 | | 29d. Date signed (Month, Day, Year) July 28, 1999 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1075 W. Perimeter Rd, Andrews AFB, MD 20762 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 29 1999 | | | | 32. Registrar's Signature B. Sparks | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26917

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN W. TRADER

2. Date of Death
Month Day Year

08

07

99

1838

3. Time of Death

4e. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

224-28-6214

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

6/2/21

9. Birthplace (State or Foreign Country)

(USA) VA

Usual Residence of Decedent

10a. State

VA.

10b. County

Accomack

10c. City, Town or Location

Hornstown VA.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

P.O. Box 104 Wilbourne Lane

10f. Zip Code

23395

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABOR

16b. Kind of Business/Industry

FARMING

17. Father's Name (First, Middle, Last)

Joseph TRADER

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte HANDY

19a. Informant's Name/Relationship (Type, Print)

Aileen Doughty

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3165 Davis Rd. New Church VA 23413

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Tabernacle Baptist Church

Date

8/13/99

20c. Location - City or Town, State

Hornstown VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bennie Smith F/H Salisbury, MD 21801

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

FRACTURED ODONTOID AND C-1, TRANSIENT ISCHEMIC

ATTACK 1998, CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

7/6/98

28b. Time of Injury

1100 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

FALL AT HOME

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

P.O. BOX 104

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HORNTOWN, VIRGINIA

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0003599

29d. Date signed (Month, Day, Year)

8-9-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOHN T. BULKELEY, M.D.

106 MILFORD STREET

SALISBURY, MARYLAND

21804

31. Date filed (Month, Day, Year)

AUG 12 1999

32. Registrar's Signature

Bennie B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

18th March 1944

Dear Sir

I have the pleasure to acknowledge the receipt of your letter of the 14th inst. in relation to the above matter. The same has been forwarded to the appropriate authorities for their consideration. I am sorry that I cannot give you a more definite answer at this time, but I will keep you informed as soon as a final decision has been reached.

Yours faithfully,
[Signature]

Very truly yours,
[Signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26918

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary Kathleen Taylor | | | | 2. Date of Death Month Day Year Aug 6, 1999 | | 3. Time of Death 3:38 AM | |
| | 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital | | | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 229- 09- 6309 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 80 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 2, 1919 | 9. Birthplace (State or Foreign Country) Virginia |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Prince George's | | 10c. City, Town or Location Accokeek | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 16009 Dusty Lane | | | | 10f. Zip Code 20607 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria Worker | | 16b. Kind of Business/Industry P.G. County School Board | | |
| 17. Father's Name (First, Middle, Last) William J. Weeks | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary M. Furr | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Virginia Hulvey (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16009 Dusty Lane, Accokeek, Maryland 20607 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery Aug 10, 1999 | | 20c. Location - City or Town, State Suitland, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Severe Chr. Lung Disease Due to (or as a consequence of): b. Dehydration hypotension Due to (or as a consequence of): c. Congestive Heart Failure Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death 1 week 72 hr 21 hr |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D-24535 | | 29d. Date signed (Month, Day, Year) 8.6.99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxmi N. Berwa 7700 Old Branch Ave C101 Clinton, Maryland 20735 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 26919**
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILLIAM PAUL THOMPSON | | | | 2. Date of Death Month Day Year August 8 1999 | | 3. Time of Death 9:31 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) 718 Bayfront Avenue | | | | 4b. City, Town, or Location of Death North Beach, MD | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 092 20 2027 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) July 10, 1927 | |
| | 9. Birthplace (State or Foreign Country) NY, NY | | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location North Beach | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 718 Bayfront Avenue | | 10f. Zip Code 20714 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1952-54 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) warehouse manager | | 16b. Kind of Business/Industry storage | | | |
| | 17. Father's Name (First, Middle, Last) William Joseph Thompson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Viane | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Paul Thompson / brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Florida Blvd., # 333, Delray Beach, FL 33843 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery | | 20c. Date 8-11-99 | | 20d. Location - City or Town, State Bronx, NY | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Non-Hodgkin's Lymphoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Were an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how Injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  Bruce A. Silver, M.D. | | | | 29c. License number D21463 | | 29d. Date signed (Month, Day, Year) 8-9-99 | | |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Bruce A. Silver, M.D. Prince Frederick, MD 20678 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26920

| | | | | | | | | | | |
|---|--|---|---|--|---|--|--------------------------------|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Vernon Milton Vermillion, Sr. | | | | 2. Date of Death Month Day Year August 8, 1999 | | | | 3. Time of Death 9:30 pm | |
| | 4a. Facility Name (If not institution, give street and number) 110 Magnolia Ave. | | | | 4b. City, Town, or Location of Death Pasadena | | | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 214-20-7286 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 72 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) Oct 8 1926 | | 9. Birthplace (State or Foreign Country) MD | | Usual Residence of Decedent | | 10a. State MD | | 10b. County Anne Arundel | |
| 10c. City, Town or Location Pasadena | | 10d. Inside City Limits 1 Yes 2 No | | 10e. Street and Number 110 Magnolia Ave. | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mill Wright | | 16b. Kind of Business/Industry Machinist | | 17. Father's Name (First, Middle, Last) Pellmon Vermillion | | 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Lowman | | 19. Informant's Name/Relationship (Type, Print) Anna Mae Vermillion/Wife | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Magnolia Ave. Pasadena, MD 21122 | | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cemetery | | 20c. Location - City or Town, State Glen Burnie, MD | | 20d. Date Aug 13 1999 | | |
| 21. Signature of Funeral Service Licensee <i>James E. Barranco</i> | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Diabetes mellitus Arteriosclerotic Cardiovascular Disease Sepsis | | 23b. Approximate Interval Between Onset and Death 10 years 5 years 3 days | | 23c. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | |
| 24a. Was an autopsy performed? 1 Yes 2 No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 Medical Examiner | | 29b. Signature and title of certifier <i>Elliott Gorbaty MD</i> | | 29c. License number 020014 | | 29d. Date signed (Month, Day, Year) 08/10/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elliott Gorbaty MD 7845 Oakwood Rd, Glen Burnie, MD, 21061 | | 31. Date filed (Month, Day, Year) AUG 12 1999 | | 32. Registrar's Signature <i>James E. Barranco</i> | | 33. Date of Death August 8, 1999 | | 34. Time of Death 9:30 pm | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26921

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John H. Veasey, Jr.

2. Date of Death

Month

Day

Year

August

12

1999

3. Time of Death

1345

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

216-38-3885

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

58

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month, Day, Year

May 14, 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

255 Hollingsworth Manor

10f. Zip Code

21921

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1958-1964

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dry Wall Hanger

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

John Henry Veasey, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Betty Jane Spencer

19a. Informant's Name/Relationship (Type, Print)

Barbara J. Veasey - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

255 Hollingsworth Manor Elkton, MD 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cherry Hill Methodist Cem.

Date

August 17, 1999

20c. Location - City or Town, State

Cherry Hill, MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Gee Funeral Home

259 E. Main St Elkton, MD - 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis - post-operation

6 days

Due to (or as a consequence of):

b. Bronchopulmonary stump fistula

6 days

Due to (or as a consequence of):

c. Acute Respiratory Distress Syndrome

6 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of Lung
Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

22307

29d. Date signed (Month, Day, Year)

8/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAYANTILAL K PATEL MD 123 SINGERLY AVE ELKTON MD 21921

31. Date filed (Month, Day, Year)

AUG 16 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 26922**
Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|--------------------------------|---|---|---|---|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edna Venables | | | | | 2. Date of Death Month August Day 9 Year 1999 | | 3. Time of Death 7:20 PM | | | |
| | 4a. Facility Name (If not institution, give street and number) Salisbury Center: Genesis ElderCare | | | | | 4b. City, Town, or Location of Death Salisbury, MD | | 4c. County of Death Wicomico | | | |
| Funeral Director | 5. Social Security Number 219-05-3292 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 25, 1905 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State md. | | 10b. County Wicomico | | 10c. City, Town or Location Salisbury | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 402 TRINITY DR. | | | | | 10f. Zip Code 21801 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1st College (1-4 or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic | | | 16b. Kind of Business/Industry | | | |
| 17. Father's Name (First, Middle, Last) unknown | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Suz Pinckett | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Edna Rubin Daughter | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8661 Doris St Delmar Md. 21825 | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Spring Hill mem Cem | | | 20c. Location - City or Town, State Abingdon, Md. | | 20d. Date 8/14/99 | | | |
| 21. Signature of Funeral Service Licensee | | | | | 22. Name and Address of Facility Brownie Smith Funeral Home 917 W. Isabella St Salisbury Md. 21801 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Dementia Alzheimer's Type Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | 29c. License number 029349 | | 29d. Date signed (Month, Day, Year) 8/10/99 | | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) William H. Robins, M.D. 1104 Healthway Dr. Salisbury, MD 21804 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1999 | | | 32. Registrar's Signature | | | | | | | | |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit data.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit data.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND: #7 & #8 mcg 8/17/99 AACO **Certificate of Death** 99 26923

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Donald White

2. Date of Death

August 10 1999

3. Time of Death

5:25 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Future Care - Chesapeake

4b. City, Town, or Location of Death

Arnold

4c. County of Death

Anne Arundel

5. Social Security Number

377-28-7907

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

69 ~~68~~ Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar 21 1931

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

Mar 21, 1930

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Arnold

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

854 Spriggs Court

10f. Zip Code

21012

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1953-195513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Operations Manager

16b. Kind of Business/Industry

Electric Supply Co.

17. Father's Name (First, Middle, Last)

Jim White

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Barr

19a. Informant's Name/Relationship (Type, Print)

Ruth White/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

854 Spriggs Court Arnold, MD 21012

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory

Date

Aug 13 1999

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy Severna Park, MD 2114623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

DEMENTIA

Approximate
Interval Between
Onset and Death

3 YEARS

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D21776

29d. Date signed (Month, Day, Year)

AUGUST 12 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURYA P. MUNDRA 8109 RITCHIE HWY PASADENA MD 21122

State
Registrar

31. Date filed (Month, Day, Year)

AUG 16 1999

32. Registrar's Signature

S. B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26924

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

JULIAN LAWRENCE WHITLOCK

2. Date of Death

August 09, 1999 09:55PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

Cecil

5. Social Security Number

218-18-3019

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

February 23, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

North East

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

122 3rd Street, Red Point

10f. Zip Code

21901

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give US Army Year or Dates: 1941-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assembly Line Worker

16b. Kind of Business/Industry

Automobile Manufacturer

17. Father's Name (First, Middle, Last)

Julian Lee Whitlock

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Mae Whitlock (Whitlock is maiden name)

19a. Informant's Name/Relationship (Type, Print)

Judith Whitlock / Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

122 3rd Street, Red Point, North East, MD 21901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

North East Methodist Cem. 1999

Date

Aug. 13

20c. Location - City or Town, State

North East, Maryland

21. Signature of Funeral Service Licensed

22. Name and Address of Facility

Crouch Funeral Home

127 South Main Street, North East, MD 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Severe pulmonary hypertension

4 years

Due to (or as a consequence of):

b. Valvular heart disease

4 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20215

29d. Date signed (Month, Day, Year)

August 09, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARMACHANDRA NAIR, M.D., VA Maryland Health Care System, Perry Point, MD 21902

31. Date filed (Month, Day, Year)

AUG 11 1999

32. Registrar's Signature

B. Spates

State
RegistrarNAME KNOWN TO PHYSICIAN: JULIAN WHITLOCK
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DATE 10-10-2001 BY SP-6 JAC/STP

Page 2

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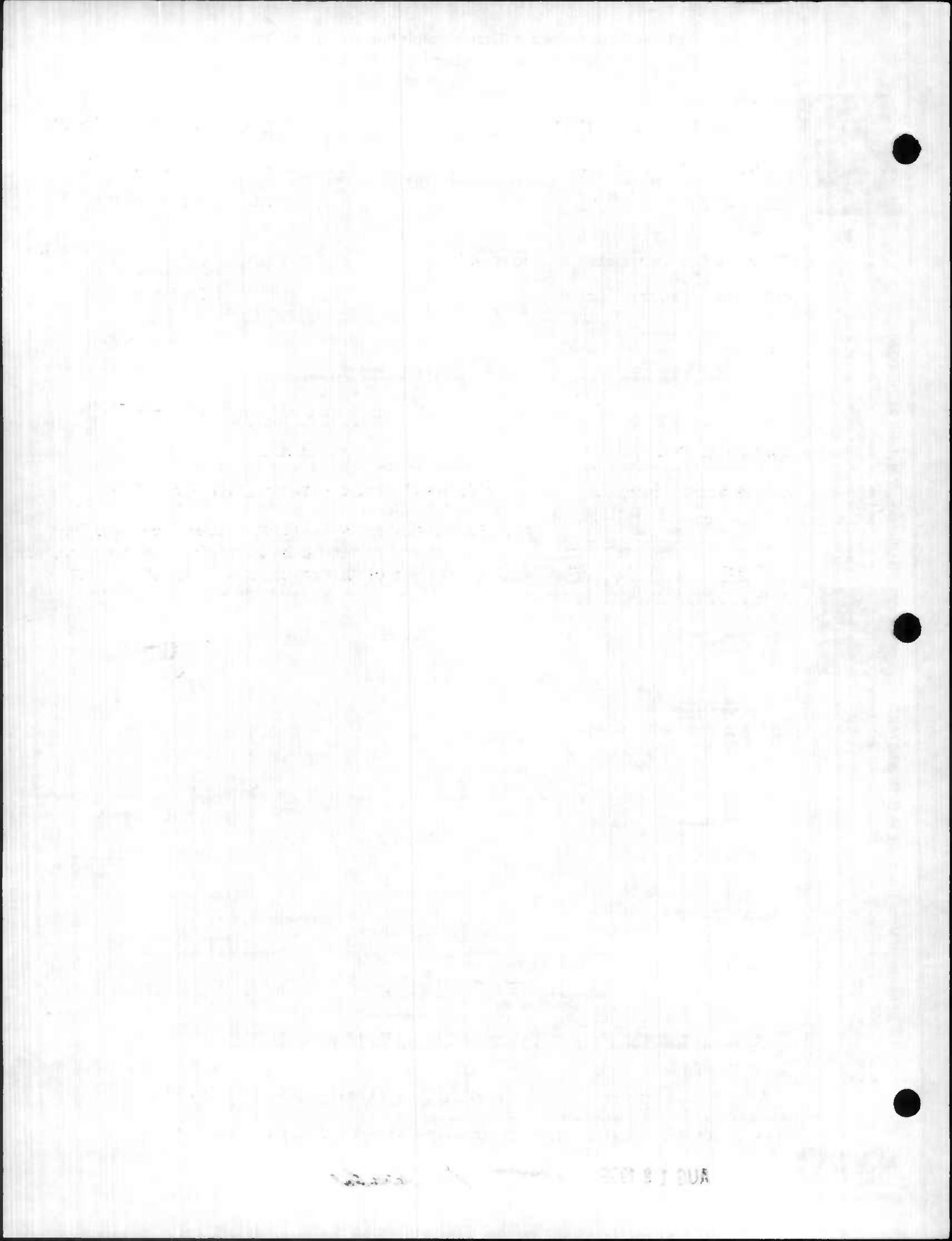
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relationship between the two

26925

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26926

| | | | | | |
|---|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) William Howard Wannall, Jr. | | 2. Date of Death Month July Day 22 Year 1999 | | 3. Time of Death 3:00PM |
| | 4a. Facility Name (If not institution, give street and number) 17841 Clarke Road | | 4b. City, Town, or Location of Death Piney Point | | 4c. County of Death St. Mary's |
| Funeral Director | 5. Social Security Number 578 36 6678 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) May 1, 1928 | | 9. Birthplace (State or Foreign Country) Washington DC | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County P.G. | | 10c. City, Town or Location Clinton |
| | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number 10501 Dee Lane | | 10f. Zip Code 20735 | | 10g. Citizen of What Country? United States |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) General Supervisor | | 16b. Kind of Business/Industry PEPCO |
| | 17. Father's Name (First, Middle, Last) William Howard Wannall, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname) Tayman | | |
| | 19a. Informant's Name/Relationship (Type, Print) William H. Wannall, III (SON) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6199 Seal Place, Waldorf, Maryland 20603 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery | | 20c. Location - City or Town, State Clinton, Maryland |
| | 21. Signature of Funeral Service Licensee [Signature] | | 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) a. Probable Myocardial Infarction Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier [Signature] | | 29c. License number D14285 | | 29d. Date signed (Month, Day, Year) 7-23-99. | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) JUL 26 1999 | | 32. Registrar's Signature [Signature] | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26927

| | | | | | | | | | | |
|---|--|---|--|--|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILTON | | | | 2. Date of Death Month JULY Day 22 Year 1999 | | | | 3. Time of Death 14:55 pm | |
| | 4e. Facility Name (If not Institution, give street and number) Calvert Memorial Hospital | | | | 4b. City, Town, or Location of Death Prince Frederick | | | | 4c. County of Death Calvert | |
| Funeral Director | 5. Social Security Number 214-18-8297 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth Month May Day 26 Year 1919 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State Maryland | | 10b. County Calvert | | 10c. City, Town or Location Chesapeake Beach | | | | 10d. Inside City Limits 1 Yes 2 No | |
| | 10e. Street and Number 3737 Dalrymple Road | | | | 10f. Zip Code 20732 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | 16b. Kind of Business/Industry Construction | | |
| | 17. Father's Name (First, Middle, Last) Walter T. Ward | | | | 18. Mother's Name (First, Middle, Maiden Surname) Annie Jones | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Wilton Ward/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 129 Chesapeake Beach, MD 20732 | | | | | |
| | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Edmonds UMC Cemetery | | 20c. Date 7/28/99 | | 20d. Location - City or Town, State Chesapeake Beach, MD | | | |
| | 21. Signature of Funeral Service Licensee Bladys A. Sewell | | | | 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 | | | | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) Prostate Cancer | | | | | | | | |
| Due to (or as a consequence of): Sepsis Syndrome | | | | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 Yes 2 No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier Joseph J. Barth M.D. | | | | 29c. License number D0052242 | | 29d. Date signed (Month, Day, Year) July 23, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Joseph Barth, M.D., Prince Frederick, Maryland 20678 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 26 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | |
| | State Registrar | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26928

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Margaret Ellen Wilson | | | | 2. Date of Death Month August Day 3 Year 1999 | | 3. Time of Death 4:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) Salisbury Center: Genesis ElderCare | | | | 4b. City, Town, or Location of Death Salisbury, MD | | 4c. County of Death Wicomico | |
| Funeral Director | 5. Social Security Number 221-09-2088 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN. 3, 1916 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MARYLAND | | 10b. County WICOMICO | | 10c. City, Town or Location SALISBURY | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 902 RUSSELL AVE | | 10f. Zip Code 21801 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY | | 16b. Kind of Business/Industry HOSPITAL | | | | |
| 17. Father's Name (First, Middle, Last) ROBERT L. WILSON, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARIAN E. MESSICK | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ROBERT E. WILSON, JR. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 154 MARDELA SPRINGS, MD 21837 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MARDELA MEMORIAL CEMETERY | | 20c. Location - City or Town, State 8/5/99 MARDELA SPRINGS, MD | | | | |
| 21. Signature of Funeral Service Licensee B. Keitt P. Lippert, CFSP | | 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. UNOsepsis Due to (or as a consequence of): b. Severe Dehydration + malnutrition Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death 30 days months | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic Stenosis | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and Title of certifier M. W. MD | | 29c. License number D39815 | | 29d. Date signed (Month, Day, Year) 8/3/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. ARKINS 1109 Westbury Drive, Spils, MD 21804 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1999 | | 32. Registrar's Signature Benita B. Sparks | | | | | | |

ORIGINAL

Handwritten text at the bottom of the page, possibly a signature or date, followed by the printed text "JAN 1962".

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26929

| | | | | | | | | | | | |
|---|---|-------------------------------|---|---|--|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LINNAE COLLEEN WILKINSON | | | | | | 2. Date of Death Month August Day 6 Year 1999 | | 3. Time of Death 11:25 p.m. | | |
| | 4a. Facility Name (If not institution, give street and number) 6905 Southern Maryland Blvd. | | | | | | 4b. City, Town, or Location of Death Owings | | 4c. County of Death Calvert | | |
| Funeral Director | 5. Social Security Number 220 36 0002 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 73 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan 15, 1926 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Calvert | | 10c. City, Town or Location Owings | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 6905 Southern Maryland Blvd. | | | | 10f. Zip Code 20736 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) bank administrator | | | 16b. Kind of Business/Industry banking | | | | |
| 17. Father's Name (First, Middle, Last) James Stanley Russell, Sr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Verna Boyd | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Orville A. Wilkinson, Sr. | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as # 10 above | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Harmony Church Cem. | | 20c. Location - City or Town, State 8-10-99 Owings, MD | | | | | |
| 21. Signature of Funeral Service Licensee William R. [Signature] | | | | | | 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | Approximate interval Between Onset and Death 16 months | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Joyce A. Owens, MD | | | | 29c. License number 047313 | | | |
| | | | | 29d. Date signed (Month, Day, Year) 8/9/99 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10845 Towncenter Blvd # 203 Dunkirk, MD 20754 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | | | 32. Registrar's Signature [Signature] | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at office.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26930

| | | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) KENNETH RAY YOUNG | | | | 2. Date of Death Month Day Year AUGUST 9 1999 | | 3. Time of Death 4:30 AM | | | |
| | 4a. Facility Name (If not institution, give street and number) FROSTBURG NURSING HOME | | | | 4b. City, Town, or Location of Death FROSTBURG | | 4c. County of Death ALLEGANY | | | |
| Funeral Director | 5. Social Security Number 705-10-7995 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) JUNE 13 1907 | | | |
| | 10e. State W. VA. | | 10b. County MINERAL | | 10c. City, Town or Location RIDGELEY | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| Usual Residence of Decedent | | | | 10f. Zip Code 26753 | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WESTERN MARYLAND RAILROAD | | 16b. Kind of Business/Industry SHOP FOREMAN | | | | |
| 17. Father's Name (First, Middle, Last) CHARLES WILLIAM YOUNG | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNIE STRAHIN | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JOSEPHINE MILLER NIECE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14003 CEDARWOOD DRIVE S.W. CUMBERLAND MD 21502 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) SUNSET CEMETERY | | Date AUGUST 11 1999 | | 20c. Location - City or Town, State CUMBERLAND MARYLAND | | |
| 21. Signature of Funeral Service Licensee Dale L. Merritt | | | | 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIAC ARREST Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE c. HYPER TENSION d. Due to (or as a consequence of): Approximate Interval Between Onset and Death ONE HOUR 4 DAYS | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | |
| 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Paul Low - Aug 9, 1999 | | | | 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Charles Hyon L. M.D. | | 29c. License number D 24951 | | 29d. Date signed (Month, Day, Year) AUGUST 9, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR CHANG-HYUN OH 219 SHAW STREET FROSTBURG, MARYLAND 21532 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 10 1999 | | | | 32. Registrar's Signature S. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26931

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret E. Bitzel

2. Date of Death
Month Day Year
August 21, 19993. Time of Death
7PM

4a. Facility Name (If not institution, give street and number)

2673 West Park Drive

4b. City, Town, or Location of Death

Woodlawn

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

212-01-1009

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 8, 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Woodlawn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2673 West Park Drive

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8College (1-4 or 5+)
-0-16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Schaefer

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Davault

19a. Informant's Name/Relationship (Type, Print)

Mrs. Phyllis J. Rudd Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2673 West Park Drive Baltimore, MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lorraine Park Cemetery

Date

Aug 27,

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

Stephen M Jenkins

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Road Randallstown, Maryland 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

1/2 hr

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. ASCVD
Due to (or as a consequence of):

10 yr

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael Pearlman, MD

29c. License number

D13557

29d. Date signed (Month, Day, Year)

8-23-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL PEARLMAN, MD 5400 Old Court Rd, Suite 204, RANDALLSTOWN, MD 21133

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-251-2000.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26932

| | | | | | | | | | | |
|---|--|--|--|---|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Lois Angelo Burse | | | | | 2. Date of Death Month Day Year August 24 1999 | | | 3. Time of Death 7:35 PM | |
| | 4a. Facility Name (If not Institution, give street and number) Mariner Health of Forest Hill | | | | | 4b. City, Town, or Location of Death Forest Hill | | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 220-36-6221 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 96 Yrs. | | 8. Date of Birth (Month, Day, Year) May 3, 1903 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | 10c. City, Town or Location Forest Hill, Maryland | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Harford | | 10e. Street and Number 109 Forest Valley Drive | | 10f. Zip Code 21050 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th | | College (1-4 or 5+) - | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic | | 16b. Kind of Business/Industry Different Homes | | | |
| | 17. Father's Name (First, Middle, Last) unknown | | | | | 18. Mother's Name (First, Middle, Maiden Surname) unknown | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) William Sellman Howser (Friend) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3865 Colwyn Drive Jarriottsville, MD 21084 | | | | |
| Physician /Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery August 27, 1999 | | 20c. Location - City or Town, State Pikesville, MD | | 21. Signature of Funeral Service Licensee Joseph J. Keller M00333 | | 22. Name and Address of Facility Loring Byers Funeral Directors 8728 Liberty Rd. Randallstown, MD 21133-4784 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Dementia</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 10 years | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>- Urinary Tract Infection</u> <u>- Anemia of Chronic Disease</u> | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier J. Kevin Lynch MD | | 29c. License number D35012 | | 29d. Date signed (Month, Day, Year) AUGUST 25, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Kevin Lynch MD 2 North Ave. Bel Air, MD. 21014 | | 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature Dana B. Sparks | | | | | | |
| State Registrar | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Joseph K. Miller, M.D.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26933

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | | | |
|---|--|---|--|--|---|---|--------------------------------|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Vernon N. Bailey | | | | 2. Date of Death Month Day Year AUGUST 21, 1999 | | | | 3. Time of Death 1226 PM | | |
| | 4a. Facility Name (If not institution, give street and number) 2300 MOUNT ROYAL TERRACE APARTMENT # 4 | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death | | |
| Funeral Director | 5. Social Security Number 213-78-1937 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 36 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | |
| | 8. Date of Birth (Month, Day, Year) 11/4/1962 | | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3801 Chesley Avenue | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auto Mechanic | | 16b. Kind of Business/Industry Self Employed | | | | | |
| 17. Father's Name (First, Middle, Last) Vernon Elmer Bailey | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Patricia Kemp | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary P. Bailey | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3801 Chesley Avenue Baltimore, Maryland 21206 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery | | Date 8/25/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COCAINE, NARCOTIC AND ALCOHOL INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) Found: 8-21-99 | | 28b. Time of Injury Found: 11:55 A M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred UNKNOWN | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: APARTMENT | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2300 MT. ROYAL TERRACE BALTIMORE, MD | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier Wayne Overhill MP | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 22, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. KOROH 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26934

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elsa E. Buhl

2. Date of Death

Month

Day

Year

AUGUST 23 1999

3. Time of Death

1030 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

218-01-9353

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 11, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Fullerton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20 W. Elm Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edward Wallut

18. Mother's Name (First, Middle, Maiden Surname)

Ernestine Calal

19a. Informant's Name/Relationship (Type, Print)

Thomas Buhl

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 1328 Hanover Pennsylvania 17331

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

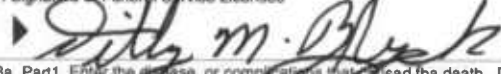
Date

8/26/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Dippel Funeral Home Inc.

7110 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

ENDOMETRIAL CANCER WITH METASTASES TO

a. Due to (or as a consequence of):

URINARY BLADDER AND LIVER

6 MONTHS

b. Due to (or as a consequence of):

c. MALNUTRITION DUE TO ENDOMETRIAL CANCER

6 MONTHS

d. Due to (or as a consequence of):

ISCHEMIC CARDIOMYOPATHY

3 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 19508

29d. Date signed (Month, Day, Year)

August 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATIVIDAD D. DE LEON M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26935

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES RAY BEDNEGO

2. Date of Death
Month Day Year

August 25 1999

3. Time of Death

10:40 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

214 20 4854

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APRIL 7 1926

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

HARFORD

10c. City, Town or Location

EDGEWOOD

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

613 CROSSGATE AVENUE

10f. Zip Code

21040

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

REAL ESTATE AGENT

16b. Kind of Business/Industry

REAL ESTATE

17. Father's Name (First, Middle, Last)

FURMAN BEDNEGO

18. Mother's Name (First, Middle, Maiden Surname)

IDA HARTLEY

19a. Informant's Name/Relationship (Type, Print)

FRANCES F. BEDNEGO / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

613 CROSSGATE AVENUE EDGEWOOD, MD 21040

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OAKLAWN CEMETERY

Date

8/28/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CVACH/ROSEDALE FUNERAL HOME

1211 CHESACO AVENUE BALTIMORE, MD 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Status Post Pneumonectomy,

Obesity, Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RD 196691

29d. Date signed (Month, Day, Year)

August 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Cherie Young 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

AUG 26 1999

32. Registrar's Signature

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Bednego, Charles
Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26936

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ellen Elizabeth Bauer | | | | 2. Date of Death Month: August Day: 25 Year: 1999 | | | | 3. Time of Death 3:25 PM | | |
| | 4a. Facility Name (If not institution, give street and number) Joseph Ritchie House | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 220-05-5113 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) May 8, 1912 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State West Virginia | | 10b. County Berkley | | 10c. City, Town or Location Martinsburg | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number 2017 N. Ridge Drive | | | | 10f. Zip Code 25401 | | 10g. Citizen of What Country? United States | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) Raymond Ziesel | | | | 18. Mother's Name (First, Middle, Maiden Surname) Grace Massey | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Judy Menacker (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2017 N. Ridge Drive Martinsburg, WV 25401 | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory | | Date 8-27-99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| 21. Signature of Funeral Service Licensee Steven T. Zittel | | | | 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Mesothelioma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death 1 yr. | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Robert C. Irwin M.D. | | | | 29c. License number 208900 | | 29d. Date signed (Month, Day, Year) 8-26-99 | | | |
| 30. Name and address of person who completed cause of death (Item 29a) (Type, Print) Robert C. Irwin M.D. 828 N. Euter St. Fx 160 Md 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature Jennifer B. Sparks | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

DHMM 16 Rev 6/95

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

8/25/99 3:25 PM

Ellen Bauer

AHS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26937

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|---|--|--|---|---|---|---|---|--|--|----|----|--|--|--|---------------------------------------|--|---|--|---|--|-----------------------------------|--|--|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ANTHONY F. BONA | | | | 2. Date of Death Month Day Year AUGUST 25 1999 | | 3. Time of Death 0615AM | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 219-28-0513 | | 6. Sex M <input type="checkbox"/> F <input type="checkbox"/> | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) MAY 4 1934 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 5813 BERKELEY AVE | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Mental Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MERCHANT MARINE | | 16b. Kind of Business/Industry SHIPPING | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) JOSEPH BONA | | | | 18. Mother's Name (First, Middle, Maiden Surname) LOUISA DELBARRONI 21215 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) DESIREE BONA (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5813 BERKELEY AVE BALTO. MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY | | 20c. Location - City or Town, State BALTO MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee [Signature] | | | | 22. Name and Address of Facility DELLA NOX & SONS FUNERAL HOME 322 S. HICK ST. BALTO 21202 MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Fo-1-uriant Hepatic Failure</td> <td rowspan="4">Approximate Interval Between Onset and Death N/A</td> </tr> <tr> <td>b. Liver Disease</td> </tr> <tr> <td>c. </td> </tr> <tr> <td>d. </td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Fo-1-uriant Hepatic Failure | Approximate Interval Between Onset and Death N/A | b. Liver Disease | c. | d. | | | | | | | | | | | | | | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death) | a. Fo-1-uriant Hepatic Failure | Approximate Interval Between Onset and Death N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. Liver Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td colspan="4">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</td> <td colspan="4">23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table> | | | | | | | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
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| | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="6">26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="2">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="3">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table> | | | | | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
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| <table border="1"> <tr> <td colspan="8">29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> </tr> <tr> <td colspan="4">29b. Signature and title of certifier [Signature]</td> <td colspan="2">29c. License number RES000</td> <td colspan="2">29d. Date signed (Month, Day, Year) AUGUST 25, 1999</td> </tr> </table> | | | | | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | 29b. Signature and title of certifier [Signature] | | | | 29c. License number RES000 | | 29d. Date signed (Month, Day, Year) AUGUST 25, 1999 | | | | | | | | | | | | |
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| 29b. Signature and title of certifier [Signature] | | | | 29c. License number RES000 | | 29d. Date signed (Month, Day, Year) AUGUST 25, 1999 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Kaufman 2401 West Belvedere, Baltimore, MD 21215 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature [Signature] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26938

| | | | | | | | | | |
|--|---|---|--|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedant's Name (First, Middle, Last) JAMES BARLOW | | | | 2. Date of Death Month AUGUST Day 24 Year 1999 | | 3. Time of Death 10:25 PM | | |
| | 4a. Facility Name (If not institution, give street and number) Church Home Hospital | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 413 16 1344 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) FEBRUARY 16, 1916 | | |
| | 9. Birthplace (State or Foreign Country) Georgia | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Dundalk | | |
| Usual Residence of Decedant | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 8002 Wallace Road | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedant Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 Years College (1-4 or 5+) Collage | |
| 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic | | 16b. Kind of Business/Industry Automobile Repair | | 17. Father's Name (First, Middle, Last) Daniel W. Barlow | | 18. Mother's Name (First, Middle, Maiden Surname) Fanny Giddens | | 19a. Informant's Name/Relationship (Type, Print) Wife Mrs. Annie Louise Barlow | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8002 Wallace Road Dundalk, Maryland 21222 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Gdns. | | 20c. Location - City or Town, State 8/27/99 Middle River, MD | | 21. Signature of Funeral Service Licensee  | |
| 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. | | 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HYPOXIC ENCEPHALOPATHY Due to (or as a consequence of): ASPIRATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3 days 3 days | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| 29b. Signature and title of certifier Abdallah J. Helou, M.D. | | 29c. License number D17695 | | 29d. Date signed (Month, Day, Year) AUGUST 24, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDALLAH J. HELOU, M.D. CHURCH HOSPITAL, 100 N. BROADWAY, BALTIMORE, MD 21231 | | 31. Data filed (Month, Day, Year) AUG 27 1999 | |
| 32. Registrar's Signature  | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Baltimore, Maryland 21215-0020
NAME KNOWN TO PHYSICIAN
Department of Health and Mental Hygiene
Important: If item 22 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26939

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT ALLEN BOENNING

2. Date of Death

Month Day Year
AUGUST 24, 1999

3. Time of Death

9:55 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

218-28-9747

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
NOV. 10, 1931

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTIMORE

10c. City, Town or Location

TIMONIUM

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2116 FOREST RIDGE RD.

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ENGINEER

16b. Kind of Business/Industry

WESTINGHOUSE

17. Father's Name (First, Middle, Last)

CARL JOSEPH BOENNING

18. Mother's Name (First, Middle, Maiden Surname)

HELEN MAY RABER

19a. Informant's Name/Relationship (Type, Print)

JANET HARRY, NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18710 FALLS RD. HAMPSTEAD, MD. 21074

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DUNN VALLEY MEM. GONS.

Date

AUG. 25,

20c. Location - City or Town, State

TIMONIUM, MD.

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

EVANS FUNERAL CHAPEL
2325 YORK RD. TIMONIUM, MD. 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CARDIOPULMONARY ARREST

Approximate Interval Between Onset and Death

HOURS

a. Due to (or as a consequence of):

CORONARY ARTERY DISEASE

YEARS

b. Due to (or as a consequence of):

MITRAL VALVE REGURGITATION

YEARS

c. Due to (or as a consequence of):

AORTIC VALVE REGURGITATION

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D0053607

29d. Date signed (Month, Day, Year)

August 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL G. BURNS M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26940

| | | | | | | | | | | | | | |
|---|---|---|--|---|--|--|--|--|---|---|--|--|----|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Eleanor Mae Bacon | | | | 2. Date of Death Month: August Day: 25 Year: 1999 | | 3. Time of Death 12:55 P.M. | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death Takoma Park | | 4c. County of Death Montgomery | | | | | | |
| Funeral Director | 5. Social Security Number 309 20 0478 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 79 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) March 18, 1920 | | | | | | |
| | 9. Birthplace (State or Foreign Country) Shelburn, IN | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | |
| 10a. State IN | | 10b. County Vigo | | 10c. City, Town or Location Terra Haute | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 1218 S. 4th Street | | | | 10f. Zip Code 47802 | | 10g. Citizen of What Country? United States | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed | | | 16b. Kind of Business/Industry Child Care Provider | | | | | | |
| 17. Father's Name (First, Middle, Last) Charles Baldwin Underhill | | | | 18. Mother's Name (First, Middle, Maiden Surname) Flora Mabel McCammon | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Charles Bacon Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13103 A. Shadyside Lane Germantown MD 20874 | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery | | 20c. Location - City or Town, State Arlington Virginia | | | | | | | |
| 21. Signature of Funeral Service Licensee <i>Todd Liller</i> | | | | 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. <i>Pneumonia</i> Due to (or as a consequence of):</td> </tr> <tr> <td>b. <i>Sepsis</i> Due to (or as a consequence of):</td> </tr> <tr> <td>c. <i>Gastric Cancer</i> Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <i>Pneumonia</i> Due to (or as a consequence of): | b. <i>Sepsis</i> Due to (or as a consequence of): | c. <i>Gastric Cancer</i> Due to (or as a consequence of): | d. |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <i>Pneumonia</i> Due to (or as a consequence of): | | | | | | | | | | | | |
| | b. <i>Sepsis</i> Due to (or as a consequence of): | | | | | | | | | | | | |
| | c. <i>Gastric Cancer</i> Due to (or as a consequence of): | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>COPD, Hypertension</i> | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Dr. David</i> Doctor | | | | 29c. License number 047714 | | 29d. Date signed (Month, Day, Year) 8/25/99 | | | | | | | |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Bobby David, 7640 Carroll Ave, Takoma Park MD 20912 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26941

AMEND ITEM: 1, 26 PER MD G774 8-27-99 WR.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last) Brian Coldeira | | 2. Date of Death Month August Day 23 Year 1999 | | 3. Time of Death 5:07pm | |
| 4a. Facility Name (If not institution, give street and number) Genesis Eldercare NH Cromwell | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore | |
| 5. Social Security Number 219-60-3113 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 46 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) MAR 14, 1953 |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Dundalk | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 842 Dunbar Road | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist | | 16b. Kind of Business/Industry Machine Shop | |
| 17. Father's Name (First, Middle, Last) Wilfred Coldeira | | 18. Mother's Name (First, Middle, Maiden Surname) Cecilia Ida Kirby | | | |
| 19a. Informant's Name/Relationship (Type, Print) Richard Scheppske/Uncle | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 North Morerick Ave. Catonsville, MD 21228 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest | | 20c. Location - City or Town, State MD Veterans Cemetery 08/27/99 Owings Mills, MD | |
| 21. Signature of Funeral Service Licensee Tom Gregor | | 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Rd. Baltimore, MD 21228 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Due to (or as a consequence of): SMOKING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 4 Weeks | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier [Signature] | | 29c. License number 1752279 | | 29d. Date signed (Month, Day, Year) 8/24/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Juram H. BALASUBRAMANIAN 4920 CAMPBELL BLVD Balto Md 21236 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature [Signature] | | | |

ORIGINAL

1. The first part of the document is a list of names and dates. The names are: John Doe, Jane Smith, and Bob Johnson. The dates are: 1/1/1980, 2/1/1980, and 3/1/1980.

2. The second part of the document is a list of names and dates. The names are: John Doe, Jane Smith, and Bob Johnson. The dates are: 1/1/1980, 2/1/1980, and 3/1/1980.

3. The third part of the document is a list of names and dates. The names are: John Doe, Jane Smith, and Bob Johnson. The dates are: 1/1/1980, 2/1/1980, and 3/1/1980.

4. The fourth part of the document is a list of names and dates. The names are: John Doe, Jane Smith, and Bob Johnson. The dates are: 1/1/1980, 2/1/1980, and 3/1/1980.

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26942

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|---|---|--------------------------------|--|--|--|--|--|---|----------------------------------|--|--|--|--|--|--|----------------------------|--|--|--|--|--|-------|----------------------------------|--|--|--|--|--|----|--|--|--|--|--|--|----|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ellwood H. Cross | | | | 2. Date of Death Month Day Year August 23 1999 | | 3. Time of Death 808 A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Sinai Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 215-09-0467 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 48 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug 26, 1920 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Lutherville | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 515 Brightfield Road | | 10f. Zip Code 21093 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Wreckmaster | | 16b. Kind of Business/Industry Railroad | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) William H. Cross | | | | 18. Mother's Name (First, Middle, Maiden Summa) Lyda Brooks | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Judy Spencer Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5018 Catalpha Road Baltimore, Maryland 21214 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial | | 20c. Location - City or Town, State 8/26/1999 Eldersburg, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee Lynn B. Henss | | 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 21211 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">a. Acute Myocardial Infarction</td> <td rowspan="4">Approximate Interval Between Onset and Death minutes</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="6">b. coronary artery disease</td> <td rowspan="2">years</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">c.</td> <td></td> </tr> <tr> <td colspan="6">d.</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Acute Myocardial Infarction | | | | | | Approximate Interval Between Onset and Death minutes | Due to (or as a consequence of): | | | | | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. coronary artery disease | | | | | | years | Due to (or as a consequence of): | | | | | | c. | | | | | | | d. | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Myocardial Infarction | | | | | | Approximate Interval Between Onset and Death minutes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. coronary artery disease | | | | | | | years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. hypertension dementia Alzheimer type | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Louis W. Mullen MD | | 29c. License number D07421 | | 29d. Date signed (Month, Day, Year) 8/23/99 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOUIS W. MULLEN 1838 Greene Tree Rd #302 21208 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature Lynn B. Sparks | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

99 26943

AMEND: #23 PART I, 27, 28A-F PER MEO G775 9-1-99 WMI

Certificate of Death

Reg. No.

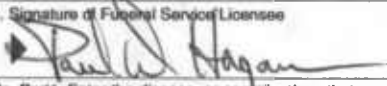


| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GLENN A. CONNER | | | | 2. Date of Death Month Day Year AUGUST 23, 1999 | | 3. Time of Death 0941 AM | |
| | 4a. Facility Name (If not institution, give street and number) 8053 DELHAVEN ROAD | | | | 4b. City, Town, or Location of Death DUNDALK | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 213-68-9803 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 42 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 2, 1957 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) Maryland | | 10. Under 1 Year Months Days | | 10. Under 24 Hrs. Hours Min. | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Dundalk | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 8053 Del Haven Road | | | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (14 or 5+) College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dry Wall Mechanic | | 16b. Kind of Business/Industry Construction | | | |
| | 17. Father's Name (First, Middle, Last) Ernest Glenn Conner | | | | 18. Mother's Name (First, Middle, Maiden Surname) Clara Louise Cooper | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Louis D. Conner/Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7520 Rabon Ave. Dundalk, Maryland 21222 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | Date 8/26/1999 | | 20c. Location - City or Town, State Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee <i>John D. King</i> | | | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COCAINE AND NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) FOUND: AUG 23, 1999 | | 28b. Time of Injury FOUND: 9:30 AM | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred UNKNOWN | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) RESIDENCE | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8053 DEL HAVEN ROAD, DUNDALK, MD. | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and Title of certifier <i>Theodore M. King</i> | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 24, 1999 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature <i>Benjamin B. Sparks</i> | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26944

| | | | | | | | | |
|--|---|---|--|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Joe R. Covert | | | | 2. Date of Death Month August Day 25 Year 1999 | | 3. Time of Death 2³⁰ pm | |
| | 4a. Facility Name (If not institution, give street and number) University of Maryland Medical Systems | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 401-58-4816 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 57 Yrs. | | 8. Date of Birth (Month, Day, Year) DEC. 17, 1941 | |
| | 9. Birthplace (State or Foreign Country) ILLINOIS | | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location GLEN BURNIE | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 405 HOWARD MANOR DRIVE | | 10f. Zip Code 21060 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1960- If Yes, Give Year or Dates: 1963 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (14 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER | | 16b. Kind of Business/Industry CLEANING FRANCHISE | | | | |
| 17. Father's Name (First, Middle, Last) GLEN COVERT | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARY JONES | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MRS. JANET COVERT (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 HOWARD MANOR DRIVE, GLEN BURNIE, MD. 21060 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GORDON CEMETERY | | Date 8/31/99 | | 20c. Location - City or Town, State DANVILLE, ILLINOIS | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aneurysm Bleed Due to (or as a consequence of): b. Intercranial Hemorrhage Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number AU4176435512451 | | 29d. Date signed (Month, Day, Year) August 26, 1999 | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Nikav Shah MD 22 S. Greene Street Baltimore | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature  | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26945

| | | | | | | | | | |
|---|---|--|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marie A. Deese | | | | 2. Date of Death Month Day Year August 27 1999 | | 3. Time of Death 5:40 am | | |
| | 4a. Facility Name (If not institution, give street and number) Knollwood Manor | | | | 4b. City, Town, or Location of Death Millersville | | 4c. County of Death Anne Arundel | | |
| Funeral Director | 5. Social Security Number 219-16-6238 | | 6. Sex 1 <input type="checkbox"/> M 3 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) April 4, 1912 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Millersville | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 503 Windy Knolls Court | | 10f. Zip Code 21108 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | 17. Father's Name (First, Middle, Last) George Sebold | | 18. Mother's Name (First, Middle, Maiden Surname) Lavina A. McGettigan | |
| 19a. Informant's Name/Relationship (Type, Print) Winnie H. Humberson (Daughter-in-law) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 Windy Knolls Court, Millersville, MD 21108 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) National Memorial Park | | 20c. Location - City or Town, State Falls Church, VA | |
| 21. Signature of Funeral Service Licensee Nicholas P. Hutter | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <u>malnutrition and dehydration</u> Due to (or as a consequence of): b. <u>Hepatitis</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death months 1 year | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Coronary artery disease, Hypertension</u> <u>Congestive heart failure (chronic)</u> <u>Dilated common bile duct, possible tumor</u> | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier [Signature] M.D. | | 29c. License number D25000 | | 29d. Date signed (Month, Day, Year) August 27, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Du-Hsieh Hung M.D. 1916 Crain Hwy, SW, #8 Glen Burnie, Md. 21049 | | 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature [Signature] | | | | | |

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State of Maryland / Department of Health and Mental Hygiene 99 26946

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | | | | | | | | | |
|--|---|---|---|--|---|---------------------------------------|----------------------------------|--------------------|----------------------------------|----------------------------------|--------------------|----------------------------------|----------------------------------|--------------------|---------------|----------------------------------|-------------------|
| 1. Decedent's Name (First, Middle, Last) <i>Dominic DuBois Sr.</i> | | 2. Date of Death Month <i>August</i> Day <i>21</i> Year <i>1999</i> | | 3. Time of Death <i>1748</i> | | | | | | | | | | | | | |
| 4a. Facility Name (If not institution, give street and number) <i>Union Memorial Hospital</i> | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>N/A</i> | | | | | | | | | | | | | |
| 5. Social Security Number <i>213-62-0501</i> | 6. Sex <i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>47</i> Yrs. | If Under 1 Year Months Days | 8. Date of Birth (Month, Day, Year) <i>Feb. 28, 1952</i> | 9. Birthplace (State or Foreign Country) <i>Maryland</i> | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | |
| 10a. State <i>Maryland</i> | 10b. County <i>N/A</i> | 10c. City, Town or Location <i>Baltimore</i> | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | |
| 10e. Street and Number <i>201 South Broadway</i> | | 10f. Zip Code <i>21231</i> | | 10g. Citizen of What Country? <i>USA</i> | | | | | | | | | | | | | |
| 11. Marital Status <i>3</i> <input type="checkbox"/> Never Married <i>2</i> <input type="checkbox"/> Married <i>3</i> <input type="checkbox"/> Widowed <i>4</i> <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <i>1</i> <input type="checkbox"/> Yes <i>2</i> <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> <input type="checkbox"/> Yes <i>2</i> <input checked="" type="checkbox"/> No Specify: | | | | | | | | | | | | | |
| 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | | 15. Decedent's Education (Specify only highest grade completed) <i>11</i> Elementary/Secondary (0-12) College (1-4 or 5+) | | | | | | | | | | | | | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Cabinet Maker</i> | | 16b. Kind of Business/Industry <i>Cabinet Manufacture</i> | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) <i>Earl C. DuBois</i> | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Wilmer</i> | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Dominic DuBois Jr. (Son)</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>28 Stretham Court Owings Mills, Md 21117</i> | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <i>1</i> <input checked="" type="checkbox"/> Burial <i>2</i> <input type="checkbox"/> Cremation <i>3</i> <input type="checkbox"/> Removal from State <i>4</i> <input type="checkbox"/> Donation <i>5</i> <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>New Cathedral Cemetery</i> | | 20c. Location - City or Town, State <i>8/27/99 Baltimore, Maryland</i> | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee <i>Lynn B. Henss</i> | | 22. Name and Address of Facility <i>Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland</i> | | | | | | | | | | | | | | | |
| 23a. Pertinent to the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td>a. <i>Anoxic Brain Injury / Death</i></td> <td>Due to (or as a consequence of):</td> <td><i>Twelve Days</i></td> </tr> <tr> <td>b. <i>Gastrointestinal Bleed</i></td> <td>Due to (or as a consequence of):</td> <td><i>Twelve Days</i></td> </tr> <tr> <td>c. <i>Cardiopulmonary Arrest</i></td> <td>Due to (or as a consequence of):</td> <td><i>Twelve Days</i></td> </tr> <tr> <td>d. <i>HIV</i></td> <td>Due to (or as a consequence of):</td> <td><i>FIVE YEARS</i></td> </tr> </table> | | | | | | a. <i>Anoxic Brain Injury / Death</i> | Due to (or as a consequence of): | <i>Twelve Days</i> | b. <i>Gastrointestinal Bleed</i> | Due to (or as a consequence of): | <i>Twelve Days</i> | c. <i>Cardiopulmonary Arrest</i> | Due to (or as a consequence of): | <i>Twelve Days</i> | d. <i>HIV</i> | Due to (or as a consequence of): | <i>FIVE YEARS</i> |
| a. <i>Anoxic Brain Injury / Death</i> | Due to (or as a consequence of): | <i>Twelve Days</i> | | | | | | | | | | | | | | | |
| b. <i>Gastrointestinal Bleed</i> | Due to (or as a consequence of): | <i>Twelve Days</i> | | | | | | | | | | | | | | | |
| c. <i>Cardiopulmonary Arrest</i> | Due to (or as a consequence of): | <i>Twelve Days</i> | | | | | | | | | | | | | | | |
| d. <i>HIV</i> | Due to (or as a consequence of): | <i>FIVE YEARS</i> | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <i>1</i> <input type="checkbox"/> Yes <i>2</i> <input type="checkbox"/> No <i>3</i> <input type="checkbox"/> Probably <i>4</i> <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <i>1</i> <input type="checkbox"/> Yes <i>2</i> <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <i>1</i> <input type="checkbox"/> Yes <i>2</i> <input type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <i>1</i> <input type="checkbox"/> Yes <i>2</i> <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <i>1</i> <input checked="" type="checkbox"/> Inpatient <i>2</i> <input type="checkbox"/> ER/Outpatient <i>3</i> <input type="checkbox"/> DOA Other: <i>4</i> <input type="checkbox"/> Nursing Home <i>5</i> <input type="checkbox"/> Residence <i>6</i> <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <i>1</i> <input checked="" type="checkbox"/> Natural <i>5</i> <input type="checkbox"/> Pending investigation <i>2</i> <input type="checkbox"/> Accident <i>6</i> <input type="checkbox"/> Could not be determined <i>3</i> <input type="checkbox"/> Suicide <i>4</i> <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | | | | | | | | | | | | |
| 28c. Injury at Work? <i>1</i> <input type="checkbox"/> Yes <i>2</i> <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <i>1</i> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Don M. L...</i> | | 29c. License number <i>Ar 2798846 P24</i> | | 29d. Date signed (Month, Day, Year) <i>August 21, 1999</i> | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>James Nicholson 332 Homeland Southway Baltimore MD 21212</i> | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>AUG 27 1999</i> | | 32. Registrar's Signature <i>Lynn B. Sparks</i> | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ADH
LENNY D. DOAN
99-4838-013

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26947

AMEND ITEMS: #23 PART I, 27 PER MEO G775 9-8-99 WR.

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Lenny Duane Doan | | | | 2. Date of Death Month Day Year AUGUST 18, 1999 | | 3. Time of Death 1809 PM | |
| | 4a. Facility Name (If not institution, give street and number) CARROLL COUNTY GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death WESTMINSTER | | 4c. County of Death CARROLL | |
| Funeral Director | 5. Social Security Number 183448055 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 37 Yrs. | | 8. Date of Birth (Month, Day, Year) 10-03-61 | |
| | 9. Birthplace (State or Foreign Country) Clinton Ind. | | 10a. State PA | | 10b. County Adams | | 10c. City, Town or Location Hamilton Twp. | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 9 Jefferson Dr. | | 10f. Zip Code 17301 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Mgr. | | 16b. Kind of Business/Industry Lawn & Garden | | | | |
| 17. Father's Name (First, Middle, Last) Glen Ray Doan | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Annetta Wilderman | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Laura Jane Doan | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Jefferson Dr Abbottstown Pa 17301 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation Inc | | 20c. Date 8-20-99 | | 20d. Location - City or Town, State Hampstead Md | | |
| 21. Signature of Funeral Service Licensee Stephen K. Muller | | 22. Name and Address of Facility Wetzel F.H. Hanner PA 17331 | | 22a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIOMEGALY WITH LEFT VENTRICULAR DILATATION | | Approximate Interval Between Onset and Death | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIOMEGALY WITH LEFT VENTRICULAR DILATATION | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) M | | |
| 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Thaddeus M. King | | 29c. License number OCME | | |
| 29d. Date signed (Month, Day, Year) AUGUST 19, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THE DOAN MORGUE 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature B. Sparks | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26948

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT GARRETT EMORY, SR.

2. Date of Death

Aug 25 1999 3 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

LEVINDALE NURSING CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

220 22 3327

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT 7, 1927

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2725 WALBROOK AVENUE

10f. Zip Code

21216

10g. Citizen of What Country?

U.S. OF A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

UNKNOWN

College (1-4 or 5+)

UNKNOWN

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STEEL WORKER

16b. Kind of Business/Industry

MANUFACTURER OF STEEL PISTON RINGS

17. Father's Name (First, Middle, Last)

JAMES EMORY

18. Mother's Name (First, Middle, Maiden Surname)

GEORGIA ANN BARRON

19a. Informant's Name/Relationship (Type, Print)

ROBERT G. EMORY, JR. (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5306 HADDON AVENUE BALTIMORE, MD. 21207

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY 9/1/99

Date

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Lewis T. Gwynn

22. Name and Address of Facility

LEWIS T. GWYNN FUNERAL HOME 21215-6393
4517 PARK HEIGHTS AVENUE BALTO., MD.

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End stage Chronic obstructive lung disease 71 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Respiratory failure 71 months

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Morgan MD

29c. License number

D44817

29d. Date signed (Month, Day, Year)

Aug 26 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2434 W Belvedere Ave Baltimore MD 21215

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.Emory, Robert
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26949

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) William H. Ellison 2. Date of Death August 25 1999 3. Time of Death 0027

4a. Facility Name (If not institution, give street and number) Church Hospital 4b. City, Town, or Location of Death Baltimore 4c. County of Death N/A

Funeral
Director

5. Social Security Number 220240112 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 70 Yrs. 8. Date of Birth (Month, Day, Year) JUNE 8 1929 9. Birthplace (State or Foreign Country) MARYLAND

Usual Residence of Decedent 10a. State MD 10b. County BALTIMORE 10c. City, Town or Location ROSEDALE 10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 1415 SPRING AVENUE 10f. Zip Code 21237 10g. Citizen of What Country? USA

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: WHITE 14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LONGSHOREMAN 16b. Kind of Business/Industry SHIPPING

17. Father's Name (First, Middle, Last) AARON ELLISON 18. Mother's Name (First, Middle, Maiden Surname) MARGARET unk.

19a. Informant's Name/Relationship (Type, Print) MARY C. ELLISON / WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1415 SPRING AVENUE ROSEDALE, MD 21237

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) OAK LAWN CEMETERY 20b. Place of Disposition (Name of cemetery, crematory or other place) 8/26/99 20c. Location - City or Town, State BALTIMORE, MD

21. Signature of Funeral Service Licensee [Signature] 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME
1211 CHESACO AVENUE BALTO, MD 21237

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia
Gram negative Sepsis
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
24a. Was an autopsy performed? 1 Yes 2 No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. End stage renal failure
metabolic acidosis

25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day, Year) M 28b. Time of Injury 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier [Signature] 29c. License number D0043662 29d. Date signed (Month, Day, Year) 8/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William J. Boyce, Church Hospital

31. Date filed (Month, Day, Year) AUG 27 1999 32. Registrar's Signature [Signature]

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AA10

WRC
99-4922-005

KIMBERLY
ESTEP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #27, 28D PER MEO G778 12-15-99 WR
State of Maryland Department of Health and Mental Hygiene
AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G774 8-30-99 WR

Certificate of Death

Reg. No.

99 26950

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

| | | | | | | | |
|--|--|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Kimberly Estep | | 2. Date of Death Month Day Year AUGUST 20, 1999 | | 3. Time of Death 4:40 PM. | | | |
| 4a. Facility Name (If not institution, give street and number) 113 TWIN CIR. WAY | | | 4b. City, Town, or Location of Death LANSDOWNE | | 4c. County of Death BALTIMORE | | |
| 5. Social Security Number 217-86-0669 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 33 Yrs. | | 8. Date of Birth (Month, Day, Year) 04 20 1966 | |
| 9. Birthplace (State or Foreign Country) Md | | 10a. State Md | | 10b. County Baltimore | | 10c. City, Town or Location Lansdowne | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 113 Twin Circle Way | | 10f. Zip Code 21227 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) Unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unknown | | 16b. Kind of Business/Industry Unknown | | 17. Father's Name (First, Middle, Last) Lewis Edwards | |
| 18. Mother's Name (First, Middle, Maiden Surname) Joanne Estep | | 19a. Informant's Name/Relationship (Type, Print) Lewis Edwards/Father | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2630 Masseth Ave, Balto, Md 21219 | | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore-Washington | | 20c. Date 8/28 | | 20d. Location - City or Town, State Laurel Maryland | | 21. Signature of Funeral Service Licensee | |
| 22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Road, Balto, Md 21222 | | 23a. Part I. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE NARCOTIC AND COCAINE INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day, Year) 8-20-99 | | 28b. Time of Injury Found: 4:30 | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred UNKNOWN SUBJECT TOOK DRUG | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 113 TWIN CIRCLE WAY BALTIMORE, CO., MD | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | |
| 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 21, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year) AUG 27 1999 | |
| 32. Registrar's Signature | | 33. State Registrar State Registrar | | 34. DHMH 16 Rev 6/95 | | ORIGINAL | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26951

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS

2. Date of Death

Month

Day

Year

AUGUST 20 1999

3. Time of Death

12:24 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

THE Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore, City

4c. County of Death

N/A

5. Social Security Number

218.10.7602

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 28, 1915

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

N/A

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

604 Hillstead Drive

10f. Zip Code

21022

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Furniture Business

16b. Kind of Business/Industry

Sales

17. Father's Name (First, Middle, Last)

Walter Goldstein

18. Mother's Name (First, Middle, Maiden Surname)

Rose Mintzer

19a. Informant's Name/Relationship (Type, Print)

Joann Levin / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 East Highfield Rd. Baltimore, Md. 21218

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Baltimore Washington 8/21

Date

20c. Location - City or Town, State

Laurel, Md.

21. Signature of Funeral Service Licensed

▶ [Signature]

22. Name and Address of Facility Sterling-Ashton-Schwab

736 Edmondson Ave. Catonsville, Md. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

7 DAYS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

29b. Signature and title of certifier

▶ Kenneth Bilchick, MD - Medicine Housestaff

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

August 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth Bilchick, 600 N. Wolfe Street, Baltimore, MD 21287

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

▶ [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26952

AMEND ITEM: #1 PER MD G774 8-31-99 WR.

| | | | | | |
|--|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>ANGELINA Eaddy</u> | | 2. Date of Death Month <u>Aug</u> Day <u>13</u> Year <u>1999</u> | | 3. Time of Death <u>4:45 pm</u> |
| | 4a. Facility Name (If not institution, give street and number) <u>HARBOR Hosp</u> | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>N/A</u> |
| Funeral Director | 5. Social Security Number <u>214-54-2834</u> | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>50</u> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) <u>04/14/49</u> | | 9. Birthplace (State or Foreign Country) <u>Alabama</u> | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State <u>MD</u> | | 10b. County <u>N/A</u> |
| | 10c. City, Town or Location <u>Baltimore</u> | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number <u>206 Key Avenue</u> | | 10f. Zip Code <u>21225</u> | | 10g. Citizen of What Country? <u>USA</u> |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u> | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th Grade</u> College (1-4 or 5+) <u></u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>DOMESTIC</u> |
| | 16b. Kind of Business/Industry <u>HOME</u> | | 17. Father's Name (First, Middle, Last) <u>JAMES McLEMORE</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>JANNIE THOMPSON</u> |
| | 19a. Informant's Name/Relationship (Type, Print) <u>DARLENE McCOMBS/SISTER IN LAW</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1243 LIMIT AVENUE, BALTIMORE, MD 21239</u> | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>MT. ZION CEMETERY</u> | | 20c. Location - City or Town, State <u>8/19/99 BALTIMORE, MD</u> |
| | 21. Signature of Funeral Service Licensee <u>VAUGHN C. GREENE, PER DVR</u> | | 22. Name and Address of Facility <u>VAUGHN C. GREENE FUNERAL SERVICE</u> <u>5151 Baltimore National Pike, Baltimore, MD 21229</u> | | |
| | Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | |
| Immediate Cause (Final disease or condition resulting in death) <u>a. Coronary Artery Disease</u> | | | | <u>> 1 yr</u> | |
| Due to (or as a consequence of): <u>b. Hypertension</u> | | | | <u>> 1 yr</u> | |
| Due to (or as a consequence of): <u>c. Obese</u> | | | | <u>> 1 yr</u> | |
| Due to (or as a consequence of): <u>d. Myocardial Infarction</u> | | | | <u>> 1 yr</u> | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Conjunctive Heart Failure</u> | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <u>M</u> | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier <u>[Signature]</u> | | 29c. License number <u>1138081</u> | | 29d. Date signed (Month, Day, Year) <u>8/13/99</u> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>H. Douglas Truckel SR HAC 631 Cherry Hill Rd 21225</u> | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) <u>AUG 27 1999</u> | | 32. Registrar's Signature <u>[Signature]</u> | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26953

| | | | | | | | | |
|---|--|--|--|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILLIAM GREIG | | | | 2. Date of Death Month JUL Day 25 Year 1999 | | 3. Time of Death 1715 | |
| | 4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL | | | | 4b. City, Town, or Location of Death SILVER SPRING | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 099-22-9141 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 70 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) OCT 25 1929 | 9. Birthplace (State or Foreign Country) GENOVESE, N. Y. |
| | Usual Residence of Decedent | | | | 10a. State DC | | 10b. County WASHINGTON | |
| 10c. City, Town or Location WASHINGTON | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3700 N. CAPITOL ST. NE | | 10f. Zip Code 20317 | | 10g. Citizen of What Country? U. S. A. |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PROFESSIONAL SEAMAN | | 16b. Kind of Business/Industry U.S. NAVY | | |
| 17. Father's Name (First, Middle, Last) WILLIAM GREIG Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MATTHEW A. HINTON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) USSAH/3700 N. CAPITOL ST NE WASH DC 20317 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATORY | | 20c. Location - City or Town, State JUL 29 BELTSVILLE, MD | | 21. Signature of Funeral Service Licensee John W. Lathrop, Jr. CCO 348 | | |
| 22. Name and Address of Facility LATHROP'S FUNERAL SERVICE | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute myocardial infarction Due to (or as a consequence of): b. bilateral pleural effusions Due to (or as a consequence of): c. intracerebral hemorrhage Due to (or as a consequence of): d. accidental fall downstairs | | Approximate Interval Between Onset and Death D N E | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. fracture left clavicle | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal | | 28a. Date of Injury (Month, Day, Year) JUL 13 1999 | | 28b. Time of Injury 1940 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Fell downstairs |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) HOME | | 28t. Location (Street and Number or Rural Route Number, City or Town, State) SILVER SPRING, MD 20905 | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| 29b. Signature and title of certifier Dr. N. Brecher MD ME | | 29c. License number D00428 | | 29d. Date signed (Month, Day, Year) JUL 25, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRA N. BRECHER MD | | | | 31. Date of Death (Month, Day, Year) AUG 27 1999 | | | | |
| 32. Registrar's Signature P. Sparks | | | | | | | | |

Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Handwritten text, likely bleed-through from the reverse side of the page. The text is mostly illegible due to fading and bleed-through.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26954

| | | | | | | | | | | | |
|---|---|---------------------------|---|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MIRIAM MARGARET GOLDBECK | | | | | 2. Date of Death Month Day Year August 22, 1999 | | 3. Time of Death 8:43 A.M. | | | |
| | 4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | | |
| Funeral Director | 5. Social Security Number 215-22-4463 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN. 3, 1925 | | 9. Birthplace (State or Foreign Country) MD. | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD. | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number 420 S. EAST AVE. | | | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (14 or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | | 16b. Kind of Business/Industry OWN HOME | | | |
| 17. Father's Name (First, Middle, Last) GOLDBECK | | | | | 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH WRIGHT | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ANTHONY GOLDBECK/HUSBAND | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 420 S. EAST AVE., BALTIMORE, MD. 21224 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) HOLY REDEEMER CEM. | | | Date 8/25/99 | | 20c. Location - City or Town, State BALTIMORE, MD. | | | |
| 21. Signature of Funeral Service Licensee <i>Elizabeth Selinski</i> | | | | | 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE. BALTIMORE, MD. 21224 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| | | | | | | | 24a. Was an autopsy performed? Inspection 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Dennis Chute</i> | | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) August 22, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) Aug 27 1999 | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26955

| | | | | | | | | | | | |
|---|--|--|---|--|--|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ALFRED WALTER GNEITING | | | | | 2. Date of Death Month Day Year AUGUST 25, 1999 | | 3. Time of Death 11:30 PM | | | |
| | 4a. Facility Name (If not institution, give street and number) 207 NANCY AVENUE | | | | | 4b. City, Town, or Location of Death LINTHICUM | | 4c. County of Death ANNE ARUNDEL | | | |
| Funeral Director | 5. Social Security Number 218-18-4070 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN. 9, 1924 | | 9. Birthplace (State or Foreign Country) MARYLAND | | |
| | Usual Residence of Decedent | | | | | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location LINTHICUM | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | | | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location LINTHICUM | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 207 NANCY AVENUE | | | | | 10f. Zip Code 21090 | | 10g. Citizen of What Country? U.S.A. | | | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1944- If Yes, Give Year or Dates: 1946 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR OF MAINTENANCE | | 16b. Kind of Business/Industry WESTINGHOUSE | | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) MATTHIAS GNEITING | | | | | 18. Mother's Name (First, Middle, Maiden Surname) LOUISE DURR | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) ELIZABETH E. GNEITING (WIFE) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 NANCY AVENUE, LINTHICUM, MD. 21090 | | | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK | | 20c. Date 8/28/99 | | 20d. Location - City or Town, State ELKRIDGE, MARYLAND | | | | |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death 1 Hr 10 Yr | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. Signature and title of certifier  | | |
| | 29c. License number DD7838 | | 29d. Date signed (Month, Day, Year) 8/26/99 | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN SHAVERS, N.D. 518 CAMPBELL ROAD, LINTHICUM, MD 21090 | | | | | | | | 31. Date filed (Month, Day, Year) AUG 27 1999 | | |
| | 32. Registrar's Signature  | | | | | | | | 33. State Registrar | | |

99-4763-005

NELSON
GOSNELL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26956

| | | | | | | | | | | | |
|---|---|--------------------------|---|--|--|---|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Nelson M. Gosnell | | | | | | 2. Date of Death Month Day Year AUGUST 16, 1999 | | 3. Time of Death 4:40P.M. | | |
| | 4a. Facility Name (If not institution, give street and number) 3507 BEACH ROAD | | | | 4b. City, Town, or Location of Death ESSEX | | 4c. County of Death BALTIMORE | | | | |
| Funeral Director | 5. Social Security Number 217-60-0955 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 45 Yrs. | | 8. Date of Birth (Month, Day, Year) 11/17/53 | | 9. Birthplace (State or Foreign Country) Balto. MD. | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 3507 Beach Road | | | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (14 or 5+) 3 yrs. | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Stationary Engineer | | | 16b. Kind of Business/Industry Universal Food | | | | |
| 17. Father's Name (First, Middle, Last) Lawrence L. Gosnell, Sr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gloria Hudzik | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Gloria Gosnell (Mother) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11683 Cedar Lane Kingsville, MD. 21087 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem. | | 20c. Date 8/20/99 | | 20d. Location - City or Town, State Baltimore, Maryland | | | | |
| 21. Signature of Funeral Service Licensee E. F. Lassahn | | | | | | 22. Name and Address of Facility E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Maryland 21087 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hanging Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) unknown | | 28b. Time of Injury unknown M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred self inflicted hanging | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Essex, Md 3507 Beach Rd | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier Dennis J. Chute, M.D. | | | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 17, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | | 32. Registrar's Signature B. Sparks | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26957

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH A. GAGLIARDI

2. Date of Death

AUGUST 25 1999

3. Time of Death

12:25AM

4a. Facility Name (If not institution, give street and number)

GILCHRIST CENTER

4b. City, Town, or Location of Death

BALTIMORE COUNTY

4c. County of Death

BALTIMORE

5. Social Security Number

219-16-5241

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 23, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8751 Magnolia Avenue

10f. Zip Code

21128

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs.

College (1-4 or 5+)

3 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chemical Technician

16b. Kind of Business/Industry

Allied Signal

17. Father's Name (First, Middle, Last)

J. Joseph Gagliardi

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Marie Lucas

19a. Informant's Name/Relationship (Type, Print)

Bernardine M. Gagliardi

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8751 Magnolia Avenue Perry Hall, Md. 21128

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Joseph Church Cemetery 8-28-99 Fullerton, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Lassahn Funeral Home

7401 Belair Rd. Baltimore, Maryland 21236

23a. Part or entire the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

malignant osteosarcoma

Approximate Interval Between Onset and Death

months

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Res/dance 8 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

N. Anthony Riley, M.D.

29c. License number

D25205

29d. Date signed (Month, Day, Year)

August 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Anthony Riley, M.D. Gilchrist Center 6601 N. Charles St. Balto., Md. 21204

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Gagliardi, Joseph died @ 12:25 AM 25 Aug 99

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

12x1

99 26958

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) James Gordon Gantt | | | | 2. DATE OF DEATH MONTH DAY YEAR August 23, 1999 | | 3. TIME OF DEATH 8:05 a.m. | |
| 4. SOCIAL SECURITY NUMBER 218-34-4024 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 21, 1934 | |
| 9a. FACILITY NAME (If not institution, give street and number) 14538 Bain Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Hancock | | 9c. COUNTY OF DEATH Washington | |
| 10a. STATE MD | | | | 10b. COUNTY Washington | | 10c. CITY, TOWN OR LOCATION Hancock | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 14538 Bain Road | | | |
| 10f. ZIP CODE 21750 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic | | 16b. KIND OF BUSINESS/INDUSTRY Retail Auto | | | |
| 17. FATHER'S NAME (First, Middle, Last) Lester Gantt | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Miller | | | |
| 19a. INFORMANT'S NAME (Type/Print) Cora E. Gantt/Wife | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14538 Bain Road Hancock, MD 21750 | | | |
| 20. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bethel Cemetery | | 20c. LOCATION — City or Town, State 8/25/99 Sleepy Creek, WV | | 22. NAME AND ADDRESS OF FACILITY Grove Funeral Home, P.A. 141 W. Main St. Hancock, MD 21750-0368 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Grove Funeral Home, P.A. 141 W. Main St. Hancock, MD 21750-0368 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Laryngeal cancer with metastases to lung and spine Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D30584 | | 29d. DATE SIGNED (Month, Day, Year) 8/24/99 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Laurence Greenspoon, MD; 130 W. High St.; Hancock, MD 21750 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) AUG 27 1999 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26959

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Margaret Anna Hanauer | | | | 2. Date of Death Month Day Year August 25, 1999 | | 3. Time of Death 5:45am | |
| 4a. Facility Name (If not institution, give street and number) Sunrise of Towson | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | |
| 5. Social Security Number 220-54-7298 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 97 Yrs. | | 8. Date of Birth (Month, Day, Year) July 21, 1902 | |
| 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Towson | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 7925 York Road | | 10f. Zip Code 21286 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | 17. Father's Name (First, Middle, Last) John Burkner | |
| 18. Mother's Name (First, Middle, Maiden Surname) Eliza Jane (Unknown) | | 19a. Informant's Name/Relationship (Type, Print) Robert W. Hanauer/Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 Burning Tree Road, Timonium, MD 21093 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore National Cem. | | 20c. Date 8/27/99 | | 20d. Location - City or Town, State Baltimore, Maryland | | 21. Signature of Funeral Service Location  | |
| 22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093 | | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): | | Approximate Interval Between Onset and Death years | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Due to (or as a consequence of): | | c. Due to (or as a consequence of): | | d. Due to (or as a consequence of): | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number 019423 | | 29d. Date signed (Month, Day, Year) August 26, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward Miller, MD 5601 Loch Raven Blvd., Balto., MD 21239 | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26960

FRANK HEDRICK
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Frank Bernard Hedrick, Jr. | | | | 2. Date of Death Month August Day 23 Year 1999 | | 3. Time of Death 7:50 PM | |
| 4a. Facility Name (If not institution, give street and number) Mariner Health Care | | | | 4b. City, Town, or Location of Death Catonsville | | 4c. County of Death Baltimore | |
| 5. Social Security Number 216-12-5548 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) December 27, 1919 | |
| 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County - | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 5308 Norwood Avenue | | 10f. Zip Code 21207 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shipping & Receiving Foreman | | 16b. Kind of Business/Industry Cats - Paw Heal and Sole | | 17. Father's Name (First, Middle, Last) Frank Bernard Hedrick, Sr. | |
| 18. Mother's Name (First, Middle, Maiden Surname) Mauretta Disney | | 19a. Informant's Name/Relationship (Type, Print) Robert Hedrick Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Lamport Road Reisterstown, MD 21136 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park | | 20c. Date 08/29/1999 | | 20d. Location - City or Town, State Sykesville, Maryland | | 21. Signature of Funeral Service Licensee <i>[Signature]</i> 333 | |
| 22. Name and Address of Facility Loring Byers Funeral Directors, 8728 Liberty Road Randallstown, MD 21133-4784 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cerebral thrombosis Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 2 weeks | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 23c. Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last atrial fibrillation coronary heart disease | | 23d. Due to (or as a consequence of): | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) N/A | |
| 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>[Signature]</i> MD | | 29c. License number D15872 | | 29d. Date signed (Month, Day, Year) August 24 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAROLD BUB MD 25 Main St Reisterstown 21136 | | 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar

Joseph W. Keller
1913

99 26961

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JULIANA HOLECTY | | | | 2. DATE OF DEATH MONTH DAY YEAR AUGUST 20 1999 | | 3. TIME OF DEATH 2:25 A M | |
| 4. SOCIAL SECURITY NUMBER 235-12-6534 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10/31/1914 | |
| 9a. FACILITY NAME (If not institution, give street and number) Future Care Canton Harbor Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 9914 Foxhill Road | | | | 10f. ZIP CODE 21128 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) Unknown College (1-4 or 5+) Unknown | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print) Juliana Jones | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3317 Putty Hill Avenue Baltimore, Maryland 21234 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Balto./Wash. Crematory | | DATE 8/26/99 | | 20c. LOCATION — City or Town, State Laurel, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → END STAGE ALZHEIMER'S DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. ESOPHAGEAL ULCER | | | | | | | Approximate Interval Between Onset and Death 12 YEARS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ESOPHAGEAL ULCER | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER MD | | | | 29c. LICENSE NUMBER D16619 | | 29d. DATE SIGNED (Month, Day, Year) 8/20/99 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. VERGARA - SOARES MD. 100 N. BROADWAY ST. BALTIMORE, MD. 21231 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) AUG 27 1999 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECTION 1
MAGN BOND

SECTION 2
MAGN BOND

100-75-300

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26962

| | | | | | | | | | | |
|---|--|---------------------------------|---|--|---|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harold Michael Hardy | | | | | 2. Date of Death Month August Day 26 Year 1999 | | 3. Time of Death 04:45 | | |
| | 4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 219 68 1985 | | 6. Sex 123 M 20 F | | 7. Age (In yrs. last birthday) 43 Yrs. | | 8. Date of Birth (Month, Day, Year) 02/10/1956 | | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location TURNERS STATION | | | | 10d. Inside City Limits 1 X Yes 20 No | | |
| 10e. Street and Number 116 CHESTNUT ST. | | | | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 X Never Married 20 Married 30 Widowed 40 Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 10 Yes 20 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 Yes 2 X No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 Collegia (1-4 or 5+) 3 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COMPUTER TECH. | | | 16b. Kind of Business/Industry HOSPITAL | | | |
| 17. Father's Name (First, Middle, Last) JAMES HARDY | | | | | 18. Mother's Name (First, Middle, Maiden Surname) LUCY M. BROWN | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) LUCY M. HARDY/MOTHER | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 CHESTNUT ST. TURNERS STATION, MD. 21222 | | | | | |
| 20a. Method of Disposition 1 X Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MD. NATIONAL | | Date 8/31/99 | | 20c. Location - City or Town, State LAUREL, MD. | | | |
| 21. Signature of Funeral Service Licensee James A. Morton | | | | | 22. Name and Address of Facility JAMES A. MORTON & SONS FUNERAL HOMES, INC 1701 LAURENS STREET, BALTIMORE, MD. 21217 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Methicillin resistant staphylococcal bacteremia Due to (or as a consequence of): b. Cryptococcal meningitis Due to (or as a consequence of): c. Acquired immunodeficiency syndrome Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death 9 days 6 weeks | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 10 Yes 2 X No 30 Probably 40 Unknown | | |
| 24a. Was an autopsy performed? 10 Yes 2 X No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 10 Yes 20 No | | | | | |
| 25. Was case referred to medical examiner? 10 Yes 2 X No | | | 26. Place of Death (Check only one) Hospital: 1 X Inpatient 20 ER/Outpatient 30 DOA Other: 40 Nursing Home 50 Residence 60 Other (Specify) | | | | | | | |
| 27. Manner of Death 1 X Natural 50 Pending investigation 20 Accident 60 Could not be determined 30 Suicide 40 Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 10 Yes 20 No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier Suzanne M. Caccamese, MD | | | | | 29c. License number 97486 | | 29d. Date signed (Month, Day, Year) August 26, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suzanne M. Caccamese 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | | 32. Registrar's Signature B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26963

| | | | | | |
|--|---|--|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John F. Harrison | | 2. Date of Death Month August Day 24 Year 1999 | | 3. Time of Death 10:30 AM |
| | 4a. Facility Name (If not institution, give street and number) Chesapeake Hospice House | | 4b. City, Town, or Location of Death Linthicum | | 4c. County of Death Anne Arundel |
| Funeral Director | 5. Social Security Number 218-26-5638 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 70 Yrs. | If Under 1 Year Months 0 Days 0 | If Under 24 Hrs. Hours 0 Min. 0 |
| | 8. Date of Birth (Month, Day, Year) March 6, 1929 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State Maryland | 10b. County Anne Arundel | 10c. City, Town or Location Severna Park | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 269 Ross Landing | | 10f. Zip Code 21146 | | 10g. Citizen of What Country? United States |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korean | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) College | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bureau of Engraving | | 16b. Kind of Business/Industry Printing | | |
| | 17. Father's Name (First, Middle, Last) Roland Henry Harrison | | 18. Mother's Name (First, Middle, Maiden Surname) Mildred Elizabeth Mobury | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mrs. Mae E. Harrison / Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 269 Ross Landing Severna Park, Maryland 21146 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) McKendree Church Cem. 8/28/1999 | | 20c. Location - City or Town, State Howard Co., Maryland |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Carcinoma to Liver Due to (or as a consequence of): a. 2 mon b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of Lung Carcinoma | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| State Registrar | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | |
| 28a. Date of Injury (Month, Day, Year) Aug. 25, 1999 | | | | | |
| 28b. Time of Injury M | | | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Charles Padgett MD | | | | | |
| 29c. License number D15546 | | | | | |
| 29d. Date signed (Month, Day, Year) Aug. 25, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Padgett MD, 5601 Loch Raven Blvd., Baltimore, MD 21239 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | | | | |
| 32. Registrar's Signature | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26964

| | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|----|---------------------------|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Charles</u> | | 2. Date of Death Month <u>Aug</u> Day <u>20</u> Year <u>1999</u> | | 3. Time of Death <u>03:23</u> | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) <u>Bayview Medical Center</u> | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>MD</u> | | | | | | | | | | |
| Funeral Director | 5. Social Security Number <u>215-40-2088</u> | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>59</u> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | | | | | | | | | | |
| | 8. Date of Birth (Month, Day, Year) <u>JULY 17, 1940</u> | | 9. Birthplace (State or Foreign Country) <u>MD</u> | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State <u>MD</u> | | 10b. County <u>BALTIMORE</u> | | 10c. City, Town or Location <u>NOTTINGHAM</u> | | | | | | | | | | |
| | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | 10e. Street and Number <u>6 JULIET LN. # 101</u> | | 10f. Zip Code <u>21236</u> | | 10g. Citizen of What Country? <u>U.S.A.</u> | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u>+7</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>WAGE COMMISSION</u> | | 16b. Kind of Business/Industry <u>CITY OF BALTIMORE</u> | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) <u>CARL E. HAUF</u> | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>CATHERINE HARLE</u> | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>THOMAS HAUF, BROTHER</u> | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>9520 12TH AVE. BALTIMORE, MD. 21234</u> | | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>NEW CATHEDRAL CEMETERY</u> | | Date <u>AUG. 23, 1999</u> | 20c. Location - City or Town, State <u>Baltimore, Maryland</u> | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee <u>Yvonne Christine Hardesty</u> | | 22. Name and Address of Facility <u>EVANS FUNERAL CHAPEL</u> <u>5800 HARFORD RD. PARKVILLE, MD. 21234</u> | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td><u>Respiratory Arrest</u></td> <td rowspan="4"> Due to (or as a consequence of): b. <u>71% Total Body Surface Area Burn with Inhalation Injury</u> Due to (or as a consequence of): c. <u>Sumner J. Chude</u> CERTIFICATION APPROVED BY MEDICAL EXAMINER d. </td> </tr> <tr><td colspan="2"></td></tr> <tr><td colspan="2"></td></tr> <tr><td colspan="2"></td></tr> </table> | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | <u>Respiratory Arrest</u> | Due to (or as a consequence of): b. <u>71% Total Body Surface Area Burn with Inhalation Injury</u> Due to (or as a consequence of): c. <u>Sumner J. Chude</u> CERTIFICATION APPROVED BY MEDICAL EXAMINER d. | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | <u>Respiratory Arrest</u> | Due to (or as a consequence of): b. <u>71% Total Body Surface Area Burn with Inhalation Injury</u> Due to (or as a consequence of): c. <u>Sumner J. Chude</u> CERTIFICATION APPROVED BY MEDICAL EXAMINER d. | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 23b. Dtd tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) <u>Aug 16 1999</u> | | 28b. Time of Injury <u>9:41 A M</u> | | | | | | | | | | | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred <u>Patient found rubbing EtOH on self - then ignited</u> | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u>Home</u> | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <u>#63 Juliet Ln Balt. Md 21236</u> | | | | | | | | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <u>Mark C. [Signature]</u> | | 29c. License number <u>RES-000</u> | | 29d. Date signed (Month, Day, Year) <u>Aug 20 1999</u> | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>1900 Thames St. #407 Baltimore MD 21231</u> | | | | | | | | | | | | | | | |
| 31. Date signed (Month, Day, Year) <u>AUG 27 1999</u> | | 32. Registrar's Signature <u>Seneca D. Sparks</u> | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26955

NAME: Holthaus, Charles

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Charles Richard Holthaus | | | | 2. Date of Death Month Day Year AUGUST 26, 1999 | | 3. Time of Death 12:15PM | |
| 4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | | | 4b. City, Town, or Location of Death TOWSON | | 4c. County of Death BALTIMORE | |
| 5. Social Security Number 215-30-1318 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 45 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec 10, 1933 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Parkville | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10a. Street and Number 2459 Ellis Rd | | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12YRS College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Autoworker | | 16b. Kind of Business/Industry General Motors | |
| 17. Father's Name (First, Middle, Last) Charles H. Holthaus | | | | 18. Mother's Name (First, Middle, Maiden Surname) Eleanor Ackerman | | | |
| 19a. Informant's Name/Relationship (Type, Print) Marion J. Holthaus/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2459 Ellis Rd. Parkville, MD 21234 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial | | Date 8/30/99 | | 20c. Location - City or Town, State Parkville, MD. | |
| 21. Signature of Funeral Service Licensee Andre Amato | | | | 22. Name and Address of Facility 8800 Harford Rd Evans Chapel of Memories | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | |
| Approximate Interval Between Onset and Death 4 months | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier Paul Celano, MD | | | | 29c. License number D30529 | | 29d. Date signed (Month, Day, Year) 8/26/1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL CELANO 6569 W. Charles ST, BALTIMORE, MD 21204 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | | | 32. Registrar's Signature Seneca B. Sparks | | | |

ORIGINAL

AX10

99 26966

ORIGINAL

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26967

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Fredia Marie Justus

2. Date of Death
Month Day Year

August 25, 1999 5:20 am

3. Time of Death

5:20 am

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number
217 10 5669

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)
80 Yrs.

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)
April 29, 1919

9. Birthplace (State or Foreign Country)
Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County
Baltimore

10c. City, Town or Location
Middle River

10d. Inside City Limits
1 ☐ Yes 2 ☒ No

10e. Street and Number

59 Sorgen Ct.

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.
Specify: White

15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 8
College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Housewife

16b. Kind of Business/Industry
Own Home

17. Father's Name (First, Middle, Last)

Robert Shaw

18. Mother's Name (First, Middle, Maiden Surname)

Isabelle Unk.

19a. Informant's Name/Relationship (Type, Print)

Shirley Williams (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3105 Putty Hill Ave. Baltimore, Md. 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Md. Veterans Cemetery 8/30/1999

Date

20c. Location - City or Town, State

Garrison Forest, Md.

21. Signature of Funeral Service Licensee

John W. Burkhardt

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Small Cell Lung Cancer

Due to (or as a consequence of):

1 month

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. End Stage Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

6 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Gastrointestinal Bleed, Left Anterior Descending,
Colon Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury
(Month, Day Year)

28b. Time of
Injury

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

R. R. Mathur, M.D.

29c. License number

RD 191825

29d. Date signed (Month, Day, Year)

8/25/99 5:30 am

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. R. Mathur 9000 Franklin Square Drive Baltimore, MD. 21237

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

Benny A. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Justus, Fredia

Handwritten signature or mark in the center of the page.

Handwritten text at the bottom of the page, possibly a date or reference number.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26968

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leonard Ralph Johnson

2. Date of Death

Month Day Year
AUGUST 24, 1999

3. Time of Death

10:35 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL

5. Social Security Number

029-18-1716

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
3-23-1927

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1420 Isterd Road

10f. Zip Code

21060

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1945-68

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Staff Sergeant

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

Gordon R. Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Jessie P. Cox

19a. Informant's Name/Relationship (Type, Print)

Marga Carper/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3502 Kingsley Court Apt C Pasadena MD 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Crownsville

Date

8/27/99

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Singleton Funeral Home P.A.

1 Second Ave. S.W. Glen Burnie, MD 21061

23a. Part I. Enter one disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

3 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D16608

29d. Date signed (Month, Day, Year)

AUGUST 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAM KEN LEUNG, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902

31. Date filed (Month, Day, Year)

32. Registrar's Signature

AUG 27 1999

James B. Sparks

State
RegistrarNAME KNOWN TO PHYSICIAN
LEONARD JOHNSON
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26969

| | | | | | | | | | | |
|--|---|---|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Elizabeth Kress | | | | 2. Date of Death Month Day Year August 26, 1999 | | | | 3. Time of Death 4:45am | |
| | 4a. Facility Name (If not institution, give street and number) Future Care at Canton Harbor | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death n/a | |
| Funeral Director | 5. Social Security Number 213-30-0278 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 94 Yrs. | | 8. Date of Birth (Month, Day, Year) 10-17-1904 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County n/a | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 139 N. Janney Street | | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry In own home | |
| | 17. Father's Name (First, Middle, Last) Stephen Helfer | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lena (unknown) | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) son Jerome Kress | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 N. Janney St., Baltimore, Md. 21224 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus | | Date 8/30/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee <i>Joseph N. Zannino Jr.</i> | | | | 22. Name and Address of Facility Joseph N. Zannino Jr., Funeral Home 263 S. Conkling Street, Baltimore, Maryland 21224 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute myocardial infarction</i> Due to (or as a consequence of): b. <i>Ischemic Heart Disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Thrombocytopenia</i> <i>Cerebrovascular disease</i> | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| State Registrar | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of Certifier <i>Dr. Patricia K. Patricio</i> | | | | 29c. License number D08358 | | 29d. Date signed (Month, Day, Year) Aug. 26 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Gracia K. Patricia</i> 703 S. CLINTON ST BALTIMORE MARYLAND 21224 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS 21, 22
##26 PER MD G774 8-27-99 WR.

Certificate of Death

Reg. No.

99 26970

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clara

Otis

Kandler

2. Date of Death

Month Day Year
August 16, 1999

3. Time of Death

7:00 AM

4a. Facility Name (If not institution, give street and number)

17116 Magraders Ferry Road

4b. City, Town, or Location of Death

Brandywine

4c. County of Death

Charles

5. Social Security Number

577-18-4782 A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 11, 1914

9. Birthplace (State or Foreign Country)

Virginia

Funeral
Director

Usual Residence of Decedent

10a. State

Virginia

10b. County

Fauquier

10c. City, Town or Location

Catlett

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8223 Rogues Road

10f. Zip Code

20119

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

7 Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

William Henry Taylor

18. Mother's Name (First, Middle, Maiden Surname)

Mary Etta Porter

19a. Informant's Name/Relationship (Type, Print)

Lorraine Brown-sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

670 Bella Vista Drive, Titusville, FL 32780

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillcrest memory Gardens

Date

8-18-99

20c. Location - City or Town, State

Jeffersonton VA

21. Signature of Funeral Service Licensee

CHARLES BELANGER

22. Name and Address of Facility

LEE FUNERAL HOME, INC. 6633 OLD ALEXANDRIA WARRENTON VA

Moser Funeral Home Inc. 233 Broadview Ave,

PERRY ROAD, CLINTON, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cerebral Vascular Accident

e. Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☒ Other (Specify)

SISTER'S HOME

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

0101-033227

29d. Date signed (Month, Day, Year)

8/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.L. Mauroner Jr. M.D.

555 Hospital Drive, Warrenton VA 20186

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26971

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CASIMER FELIX KOTOWSKI

2. Date of Death

Month Day Year
AUGUST 25, 1999

3. Time of Death

7:25 P.M.

4a. Facility Name (If not institution, give street and number)

GILCREST HOSPICE CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

200-09-8507

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
11/20/19

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

GLENDALE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6920 DONACHIE ROAD APT. 1102

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married

☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No WWII

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ACCOUNTANT

16b. Kind of Business/Industry

STATE OF MARYLAND

17. Father's Name (First, Middle, Last)

BOLESNAV KOTOWSKI

18. Mother's Name (First, Middle, Maiden Surname)

ANNA PODLESANA

19a. Informant's Name/Relationship (Type, Print)

MARIE KOTOWSKI

WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6920 DONACHIE ROAD APT. 1102 GLENDALE, MD 21239

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LORRAINE PARK CEMETERY

Date

8/30/99

20c. Location - City or Town, State

WOODLAWN, MD

21. Signature of Funeral Service Licensee

Heather N. Hayes

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic Bladder Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☒ Other (Specify)

Hospice

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending Investigation

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. M. A. Riley

29c. License number

D25205

29d. Date signed (Month, Day, Year)

August 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Riley GPMC 6701 N. Charles St. Baltimore, md 21209

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

B. Sparks

State Registrar

Kotowski, Casimer F. August 25, 1999 7:25 PM
Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.
AH 1241

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

99-5026-005

TIMOTHY A. LANKFORD

ASP

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G774 G775

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

9-2-98 W.D.

Certificate of Death

Reg. No.

99 26972

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

| | | | | |
|---|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Timothy Allen Lankford | | 2. Date of Death Month: AUGUST Day: 25 Year: 1999 | | 3. Time of Death 0053 |
| 4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL | | 4b. City, Town, or Location of Death ESSEX | | 4c. County of Death BALTIMORE |
| 5. Social Security Number 220 82 1772 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 38 Yrs. | 8. Date of Birth (Month, Day, Year) Jan. 31, 1961 | 9. Birthplace (State or Foreign Country) Maryland |
| Usual Residence of Decedent | | | | |
| 10a. State Maryland | 10b. County Baltimore | 10c. City, Town or Location Middle River | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 618 Carrollwood Rd. "Apt C" | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? USA |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1982 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 9 Collage (14 or 5+): | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter | | 16b. Kind of Business/Industry Residential | | |
| 17. Father's Name (First, Middle, Last) William W. Lankford Sr. | | 18. Mother's Name (First, Middle, Maiden Surname) Lena Baker | | |
| 19a. Informant's Name/Relationship (Type, Print) Joyce Barron (Sister) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2119 Redthorn Rd. Baltimore, Md. 21220 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery 8/30/1999 | | 20c. Location - City or Town, State Baltimore, Md. |
| 21. Signature of Funeral Service Licensee John W. Burkowski | | 22. Name and Address of Facility Bruzdinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Found: 8-25-99 28b. Time of Injury Found: 12:05 A 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred UNKNOWN 28e. Location (Street and Number or Rural Route Number, City or Town, State) 618 CARROLLWOOD RD. APT. C BALT CO. MD | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| 29b. Signature and title of certifier Dennis J. Chute | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) AUGUST 25, 1999 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature Dennis J. Chute | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26973

| | | | | | | | | |
|---|--|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DEBORAH VICTORIA LEE | | | | 2. Date of Death Month Day Year AUGUST 25 1999 | | 3. Time of Death 7:16am | |
| | 4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 218-58-6755 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. 49 | | 8. Date of Birth (Month, Day, Year) 06/10/1950 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 3923 Rexmere Road | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse | | 16b. Kind of Business/Industry Medical | | | | |
| 17. Father's Name (First, Middle, Last) Melvin Rogers Lee | | | | 18. Mother's Name (First, Middle, Maiden Surname) Roberta Geneva Milbourne | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Yvonne Barr / Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3529 Old York Road, Baltimore, Maryland 21218 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park, Inc. | | 20c. Date 08/31/99 | | 20d. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility The Derrick C. Jones Funeral Hm., 4611 Park Heights Ave., Baltimore, Maryland 21215 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Massive Pulmonary Embolism Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. Obstructive Apnea Due to (or as a consequence of): d. marked Obesity | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  MD | | | | 29c. License number P11391 | | 29d. Date signed (Month, Day, Year) AUGUST 25 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHEL SKAF 5601 Loch Raven Blvd Baltimore MD 21239. | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | | | 32. Registrar's Signature  | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26971

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Martha Wickes McKeever

2. Date of Death

Month Day Year
AUGUST 24 1999

3. Time of Death

04:15 AM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

095-34-1628

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 5 1933

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11 Stillway Garth

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Stanley Boyd Wickes

18. Mother's Name (First, Middle, Maiden Surname)

Winefred Sandilands

19a. Informant's Name/Relationship (Type, Print)

Robert W. McKeever/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 Stillway Garth, Cockeysville, MD 21030

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

8/27/99
Dulaney Valley Memorial Gardens

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

Lowell M. Lemmon

22. Name and Address of Facility

Lemmon Funeral Home
10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Adult Respiratory Distress Syndrome

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma lung - L+ pneumonectomy
8/16/99

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Leand MD

29c. License number

D000 6189

29d. Date signed (Month, Day, Year)

8/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL LEAND 1205 YORK RD #22 LUTHERVILLE, MD 21093

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

B. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26975

AMEND: #23 PART I, PER G774 8-27-99 WR.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FOSTER

MELVIN

JR.

2. Date of Death
Month Day Year

AUGUST 11 1999

3. Time of Death

9:25 pm

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

245-18-4946

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 8/23/15

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

508 E Coldspring Lane

10f. Zip Code

21212

10g. Citizen of What Country?

U.S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (14 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unload ships

16b. Kind of Business/Industry

Water front

17. Father's Name (First, Middle, Last)

Foster Melvin Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mammie McRAIR

19a. Informant's Name/Relationship (Type, Print)

ROSA Melvin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

508 E. Coldspring Ln. Baltimore, Md. 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARbutus mem. PK.

Date

8/18/99 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Betts Funeral Home
1129 N. CAROLINE ST. Baltimore, Md. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ATRIAL FIBRILLATION

a. ~~SUDDEN CARDIAC DEATH~~

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

MINUTES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CAD

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

P12557

29d. Date signed (Month, Day, Year)

AUGUST 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAPHAEL DODOO, 5601 LOCH RAVEN BVD, BALTIMORE MD 21239

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

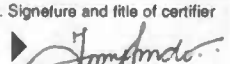
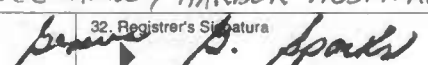
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26976

| | | | | | | | | |
|--|---|--|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) RICHARD GILMORE MARTIN | | | | 2. Date of Death Month Day Year AUGUST 23 1999 | | 3. Time of Death 10:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 217-09-9142 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 3, 1921 | |
| | 9. Birthplace (State or Foreign Country) VA | | 10a. State MD | | 10b. County Anne-Arundel | | 10c. City, Town or Location Pasadena Maryland | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 137 Club Road | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Navy WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Timekeeper | | 16b. Kind of Business/Industry Shipping | | | | |
| 17. Father's Name (First, Middle, Last) Winfield C. Martin | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Powell | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Dorothy M. Hornberger /Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 Club Road, Pasadena Maryland 21122 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | Date Aug. 27, 1999 | | 20c. Location - City or Town, State Baltimore Maryland | | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | e. PNEUMONIA Due to (or as a consequence of): b. UNRESECTABLE NONSMALL CELL CANCER Due to (or as a consequence of): c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): d. ATRIAL FIBRILLATION | | Approximate Interval Between Onset and Death 5 DAYS | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE RADIATION ESOPHAGITIS METHICILLIN RESISTANT STAPHYLOCOCCAL AUREUS SEPSIS | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  INTERN PG-41 | | 29c. License number RES 000 | | 29d. Date signed (Month, Day, Year) AUGUST 23, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TSHERING DORJEE AMDO, HARBOR HOSPITAL CENTER, 3001 SOUTH HANOVER STREET, BALTIMORE | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26977

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | | |
|---|--|---|---|--|--------------------------------|--|---|--|--------------------------------------|-----------------------------|
| 1. Decedent's Name (First, Middle, Last) JOAN DALY MURPHY | | | | | | 2. Date of Death Month Day Year August 27, 1999 | | | 3. Time of Death 2:53 A.M. | |
| 4a. Facility Name (If not institution, give street and number) 3521 Newland Road | | | | | | 4b. City, Town, or Location of Death Baltimore City | | | 4c. County of Death N/A | |
| 5. Social Security Number 212-26-1314 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 2, 1928 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore City | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 3521 Newland Road | | | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Corporate Executive | | | 16b. Kind of Business/Industry Telemarketing Agency | | | |
| 17. Father's Name (First, Middle, Last) Lee Eugene Daly | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marie Garrity | | | | |
| 19a. Informant's Name/Relationship (Type, Print) (Husband) Edward Hanlon Murphy, Sr | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3521 Newland Road, Baltimore, Maryland 21218 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory | | 20c. Location - City or Town, State Baltimore, Maryland | | 20d. Date 8/28/99 |
| 21. Signature of Funeral Service Licensee Martin D. Lawson | | | | | | 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Poorly differentiated 2 Months Due to (or as a consequence of): b. adenocarcinoma Probably gastric Due to (or as a consequence of): c. Carcinoma Primary Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier Tanet Cooper MD | | | 29c. License number D46118 | | 29d. Date signed (Month, Day, Year) Aug 27, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANET COOPER MD 1447 York RD Lutherville MD 21093 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | | 32. Registrar's Signature B. Sparks | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26978

| | | | | | | | | | | |
|--|--|---|---|---|---|--|--|-----------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Donald George McClure, Sr. | | | | 2. Date of Death Month Day Year August 26 1999 | | | | 3. Time of Death 1525 | |
| | 4a. Facility Name (If not institution, give street and number) Union Memorial Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 215-12-7398 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) August 12 1917 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10e. Street and Number 310 Ridgemed Road Unit 201 | | 10f. Zip Code 21210 | | 10g. Citizen of What Country? United States | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Financial Executive | | 16b. Kind of Business/Industry Retail Service | | | | | |
| | 17. Father's Name (First, Middle, Last) Clayton Edward McClure | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marie Shipper | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Irma V. McClure (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Ridgemed Road Unit 201 Baltimore, MD 21210 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens | | Date 8/30/99 | | 20c. Location - City or Town, State Timonium, Maryland | | | |
| | 21. Signature of Funeral Service Licensee Steven T. Bittle | | | | 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, MD 21212 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute myocardial infarction Due to (or as a consequence of): Coronary artery disease Due to (or as a consequence of): Congestive heart failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 30 min 10 years 1 year | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal failure | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Phil Buescher | | 29c. License number MD 5891 | | 29d. Date signed (Month, Day, Year) August 29, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phil Buescher 201 E. University Parkway | | 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#26 per Phy G774 8/27/99 EW

Certificate of Death

Reg. No.

99 26979

| | | | | | |
|-------------------------------------|---|--|--|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HELEN HATTIE MALLONEE | | 2. Date of Death Month Day Year AUGUST 22, 1999 | | 3. Time of Death 7:20 AM |
| | 4a. Facility Name (If not institution, give street and number) 8165 BODKIN AVENUE | | 4b. City, Town, or Location of Death PASADENA | | 4c. County of Death ANNE ARUNDEL |
| Funeral Director | 5. Social Security Number 213-20-0509 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday) 90 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) NOV. 22, 1908 | | 9. Birthplace (State or Foreign Country) ILLINOIS | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State MARYLAND | 10b. County ANNE ARUNDEL | 10c. City, Town or Location MILLERSVILLE | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 1241 INDIAN LANDING ROAD | | 10f. Zip Code 21108 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Collega (1-4 or 5+) HOMEMAKER | | |
| | 16. Kind of Business/Industry OWN HOME | | 17. Father's Name (First, Middle, Last) KAISER WILLIAM MENTECKI | | |
| | 18. Mother's Name (First, Middle, Maiden Surname) HATTIE MAGDALENE CHRISTOPHER | | 19a. Informant's Name/Relationship (Type, Print) (DAUGHTER) MRS. LORRAINE MALLONEE | | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8165 BODKIN AVENUE, PASADENA, MARYLAND 21122 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | |
| | 20b. Place of Disposition (Name of cemetery, crematory or other place) OUR LADY OF THE FIELDS | | 20c. Location - City or Town, State MILLERSVILLE, MD. | | 20d. Date 8/26/99 |
| | 21. Signature of Funeral Service Licensee <i>Michael C. Gaffney</i> | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Abdominal Cancer Due to (or as a consequence of): Coronary Artery Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 3 years 5 years |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Daughters Residence | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M |
| | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier <i>Edith Gorbaty MD</i> | | 29c. License number 020094 | | 29d. Date signed (Month, Day, Year) 08/24/99 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDITH GORBATY MD, 7845 Oakwood Rd., Glen Burnie, Md, 21061 | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature <i>James B. Sparks</i> | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

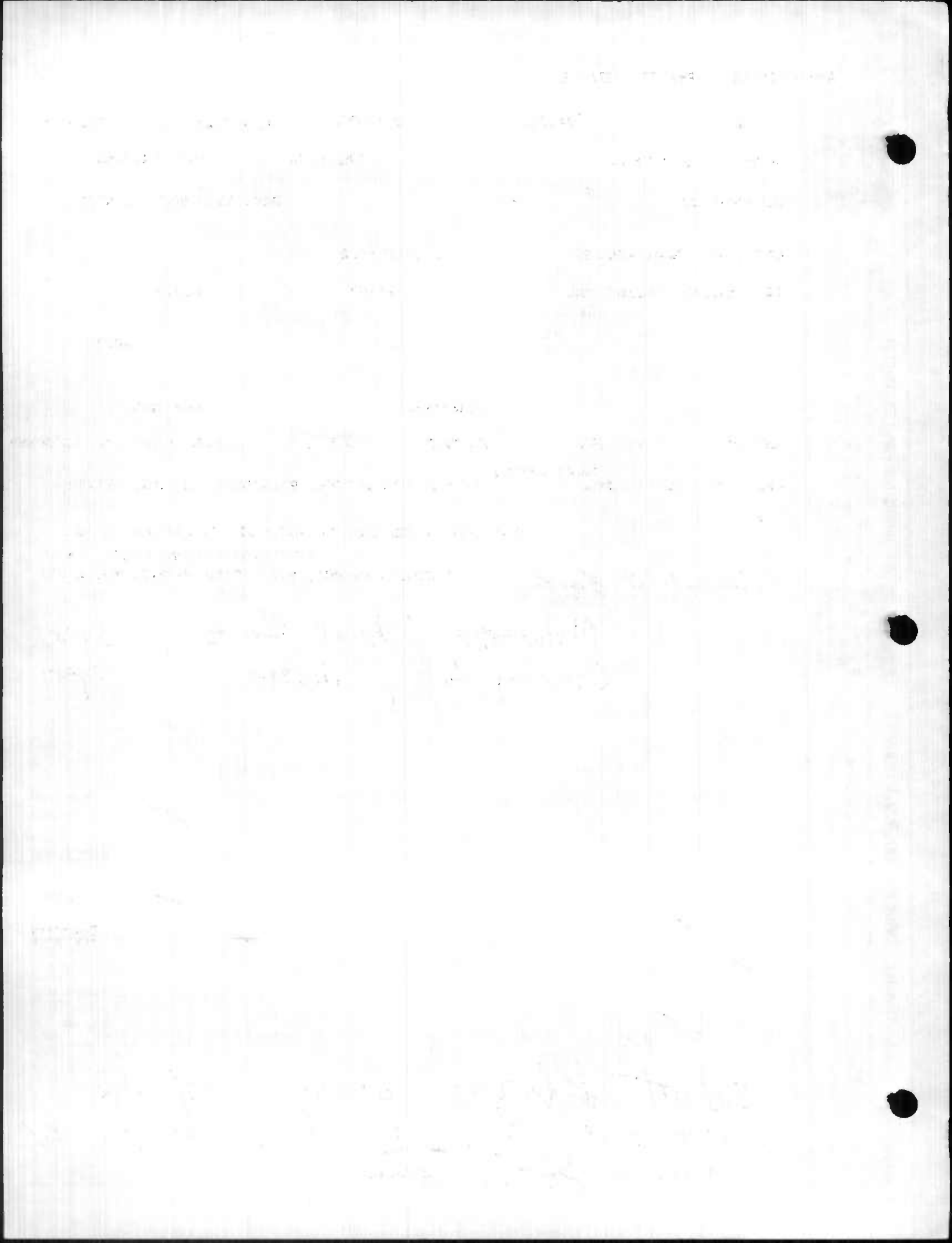
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26980

McCarthy, Marie
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

AH70

| | | | | | | | |
|--|--|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marie Louise McCarthy | | | | 2. Date of Death Month Day Year August 26 1999 | | 3. Time of Death 5:45 AM |
| | 4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death GREEN BURNIE | | 4c. County of Death ANNE ARUNDEL |
| Funeral Director | 5. Social Security Number 075 03 5434 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 19, 1913 | 9. Birthplace (State or Foreign Country) Trenton NJ |
| | Usual Residence of Decedent | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Gambrills | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 2261 September Drive | | | | 10f. Zip Code 21054 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Procurer | | 16b. Kind of Business/Industry NASA | |
| 17. Father's Name (First, Middle, Last) Sherman Jones | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marie E. Patrick | | | |
| 19a. Informant's Name/Relationship (Type, Print) Patricia A. Jacobs Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2261 September Drive Gambrills Maryland 21054 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | 20c. Location - City or Town, State Silver Spring Maryland | |
| 21. Signature of Funeral Service Licensee Michael L. Bigler | | | | 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. EXACERBATION OF CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier S. Subero MD | | | | 29c. License number 045149 | | 29d. Date signed (Month, Day, Year) August 26 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONABAGO 301 HOSPITAL DRIVE GREEN BURNIE MD 21061 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | | | 32. Registrar's Signature J. Sparks | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Lydia A. Benson

99-4978-510

cm

Unknown 99-188

EMILY MILLER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26081

| | | | | | | | | | |
|---|--|--|--|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Emily Lena Miller | | | | 2. Date of Death Month Day Year August 23, 1999 | | 3. Time of Death 10:55 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number) 6400 Block of Quad Avenue | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 214.86.4042 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 29 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 21, 1970 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 31 S. Highland Avenue | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Deli Clerk | | 16b. Kind of Business/Industry Meat Industry | | 17. Father's Name (First, Middle, Last) William Miller | | 18. Mother's Name (First, Middle, Maiden Surname) Lisa Harman | |
| 19a. Informant's Name/Relationship (Type, Print) Lisa Diehl/ Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 S. Highland Avenue Baltimore, Md. 21224 | | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore/Washington | | 20c. Date 8/30 | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Moran-Ashton-Dabrowski 3000 E. Baltimore St. Baltimore, Md. | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Blunt Force Injuries of Head and Multiple Stab and Cutting Wounds Due to (or as a consequence of): c. [Blank] Due to (or as a consequence of): d. [Blank] Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Aug 8/23/99 | | 28b. Time of Injury 1010 M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject struck, stabbed & cut | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Warehouse | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6400 block Quad Avenue Baltimore Maryland | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Theodore M. King</i> | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) August 24, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING | | 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | 33. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

mmmr

Zaira Triann Marshall

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO *Certificate of Death*

Reg. No. 99 26982

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Z-AIRA TRIANN MARSHALL

2. Date of Death

August 22, 1999

3. Time of Death

9:10 a.m.

4a. Facility Name (If not institution, give street and number)

7500 WB&A Road

4b. City, Town, or Location of Death

Severn

4c. County of Death

Anne Arundel

5. Social Security Number

135 98 3517

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

4 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 3. 1995

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

N.J.

10b. County

OCEAN

10c. City, Town or Location

LAKEWOOD

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

130 GOVERNOR ROAD

10f. Zip Code

08701

10g. Citizen of What Country?

U.S. OF A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

UNKNOWN

College (1-4 or 5+)

UNKNOWN

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

UNEMPLOYED

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

RICHARD L. MARSHALL, JR.

18. Mother's Name (First, Middle, Maiden Surname)

ODELLE J. MORRIS

19a. Informant's Name/Relationship (Type, Print)

ODELLE MORRIS (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

130 GOVERNOR ROAD LAKEWOOD, N.J. 08701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GREENWOOD CEMETERY

Date

8/28/99

20c. Location - City or Town, State

LAKEWOOD, N.J.

21. Signature of Funeral Service Licensee

Lewis T. Gwynn

22. Name and Address of Facility

LEWIS T. GWYNN FUNERAL HOME 21215-6393

4517 PARK HEIGHTS AVENUE BALTO..MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PROBABLE ANTI-HISTAMINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) wooded area

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☒ Could not be determined

28a. Date of Injury

(Month, Day, Year)

FOUND: 8-22-99

28b. Time of Injury

FOUND: M

UNKNOWN

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SUBJECT INGESTED

HIGH LEVEL OF ANTI HISTAMINE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

FATHER'S RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1711 OLD CALVERT PORT

SERVEN, MARYLAND

29a. Certifier (Check only one)

1 ☐ Certifying Physician:2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Atyiah A. Mackay

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26983

| | | | | | | | | | |
|---|--|---|--|--|---|--|---|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary Catherine Parlett | | | | 2. Date of Death Month August Day 24 Year 1999 | | 3. Time of Death 806^A | | |
| | 4a. Facility Name (If not institution, give street and number) Fallston General Hospital | | | | 4b. City, Town, or Location of Death Fallston | | 4c. County of Death Harford | | |
| Funeral Director | 5. Social Security Number 216-50-3725 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday) 86 Yrs. | 8. Date of Birth (Month, Day, Year) June 9, 1913 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | 10. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Middle River | | | | | |
| 10e. Street and Number 6234 Ebenezer Road | | | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry own home | | | |
| 17. Father's Name (First, Middle, Last) William Drayer | | | | 18. Mother's Name (First, Middle, Maiden Surname) Catherine Helldorfer | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Roland R. Parlett (son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5921 Ebenezer Road, Baltimore, Maryland 21162 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ebenezer Meth. Ch. Cem. | | 20c. Location - City or Town, State 8/27/99 Baltimore, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Bruzdinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Concognitive Heart Failure Due to (or as a consequence of): b. Myocardial Infarction Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 16 days years | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Aortic stenosis renal failure | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier MD | | 29c. License number 037517 | | 29d. Date signed (Month, Day, Year) August 29 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David C. Rubin 104 Plumtree Rd Bel Air Maryland 21015 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26984

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--------------------------|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) THOMAS E. POUGH | | | | 2. Date of Death Month Day Year 8 25 99 | | | | 3. Time of Death 1925 | |
| | 4a. Facility Name (If not institution, give street and number) North Arundel Hospital | | | | 4b. City, Town, or Location of Death Glen Burnie | | | | 4c. County of Death Anne Arundel County | |
| Funeral Director | 5. Social Security Number 148-40-2364 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 48 Yrs. | | 8. Date of Birth (Month, Day, Year) 3-15-51 | | 9. Birthplace (State or Foreign Country) NJ | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD. | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location SEVERN | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 1900 GALETOWN DR. | | | | 10f. Zip Code 21144 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12- | | College (1-4 or 5+) -0- | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR | | | 16b. Kind of Business/Industry OFFICE MOVERS | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) LEROY POUGH | | | | 18. Mother's Name (First, Middle, Maiden Surname) GWENDOLYN GALBRETH | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) CHRISTINE GARRISON(SISTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1900 GALETOWN DR. SEVERN, MARYLAND 21144 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MD. VETERANS CEMETERY | | Date 8-30-99 | | 20c. Location - City or Town, State CROWNSVILLE, MARYLAND | | | |
| | 21. Signature of Funeral Service Licensee Larry Reese | | | | 22. Name and Address of Facility WM. REESE & SONS MORTUARY 821 WEST ST. ANNAPOLIS, MARYLAND 21401 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Pancreatitis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death Three days | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier [Signature], MD | | | | 29c. License number D48006 | | 29d. Date signed (Month, Day, Year) August 25, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOF, BURNIE, 301 Hosp. Dr. Glen Burnie, MD 2106 | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 27 1999 | | | | 32. Registrar's Signature [Signature] | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26985

AMENDED ITEM #20b PER FH G778 12/7/99 AH

Amended Item #1ga per FH G774 8/31/99 FW

Richardson, Susan Wright
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

| | | | | | | | | | |
|--|--|---|--|--|---|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Susan Ellen Richardson | | | | | | 2. Date of Death Month Day Year August 23 1999 | | 3. Time of Death 3:00 AM | |
| 4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center | | | | | 4b. City, Town, or Location of Death Towson | | | 4c. County of Death Baltimore | |
| 5. Social Security Number 212-32-1422 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 97 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec. 15 1901 | | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Cockeysville | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 300 Warren Road | | | | 10f. Zip Code 21030 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Book Store Manager | | | 16b. Kind of Business/Industry University | | |
| 17. Father's Name (First, Middle, Last) John Cropper Wright | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rebecca Delphine MacMurray | | | |
| 19a. Informant's Name/Relationship (Type, Print) Anna Belle James /Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 541 Park Ave., Towson, MD 21204 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens Timonium, MD | | | 20c. Date of Disposition 8/25/99 | | |
| 21. Signature of Funeral Service Licensee Bryan W. Clary | | | | 22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. hypotension Due to (or as a consequence of): sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last extreme old age | | | | | | | | Approximate Interval Between Onset and Death 12 hrs 1 day | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier David Utzschneider | | | | 29c. License number D 52096 | | 29d. Date signed (Month, Day, Year) 8/24/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GBMC David Utzschneider, MD 6701 N. Charles St., Baltimore, MD 21204 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26986

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Lorraine Sheeler

2. Date of Death

Month
AUGUSTDay
24,Year
1999

3. Time of Death

12:55 AM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

213-46-3794

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 15 1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

604 W. Seminary Ave.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9College (1-4 or 5+)
n/a16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Nursing Asst.

16b. Kind of Business/Industry

Nursing

17. Father's Name (First, Middle, Last)

James Joseph Barron

18. Mother's Name (First, Middle, Maiden Surname)

Estelle Anna Mae Denmyer

19a. Informant's Name/Relationship (Type, Print)

John R. Sheeler, Jr./husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

604 W. Seminary Ave., Lutherville, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dulaney Valley Memorial Gardens Timonium, MD

Data
8/27/99

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home

10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

6 DAYS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. SEPSIS

Due to (or as a consequence of):

6 DAYS

c. HYPOXIA

Due to (or as a consequence of):

6 DAYS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Fred Chan M.D.

29c. License number

053430

29d. Date signed (Month, Day, Year)

AUGUST 24 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRED CHAN 6701 NORTH CHARLES STREET SUITE 3853 BALTIMORE MARYLAND 21204

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

B. Sparks

State
RegistrarSheeler, Dorothy
Baltimore, Maryland 21215-0620
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26987

| | | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Margaret Elizabeth Safko | | | | 2. Date of Death Month Day Year AUG 27, 1999 | | 3. Time of Death 3:00 AM | | | |
| | 4a. Facility Name (If not institution, give street and number) 4662 Roundhill Road | | | | 4b. City, Town, or Location of Death Ellicott City | | 4c. County of Death Howard | | | |
| Funeral Director | 5. Social Security Number 215-07-7320 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | 8. Date of Birth (Month, Day, Year) APR 13, 1914 | 9. Birthplace (State or Foreign Country) Maryland | | | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Howard | | 10c. City, Town or Location Ellicott City | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 4662 Roundhill Road | | | | 10f. Zip Code 21043 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security | | 16b. Kind of Business/Industry Federal Government | | | | | |
| | 17. Father's Name (First, Middle, Last) Joseph Armiger | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rosa Birkett | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) John Safko/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4662 Roundhill Road Ellicott City, MD 21043 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | 20c. Location - City or Town, State Baltimore, MD | | 20d. Date 8/27/99 | | | |
| | 21. Signature of Funeral Service Licensee Edward A. Gregorchik | | 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Dementia</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 6 months | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| State Registrar | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier Gary Packer | | | | 29c. License number D22527 | | 29d. Date signed (Month, Day, Year) Aug 27 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary Packer 1101 E. L. L. Parkway Columbia, Md. 21044 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature Shirley B. Sparks | | | | | | | | |

99-4965-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ALEXIS

State of Maryland / Department of Health and Mental Hygiene

SMITH AMEND ITEMS: #23 PART I, 27 PER *Certificate of Death*

Reg. No.

99 26988

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

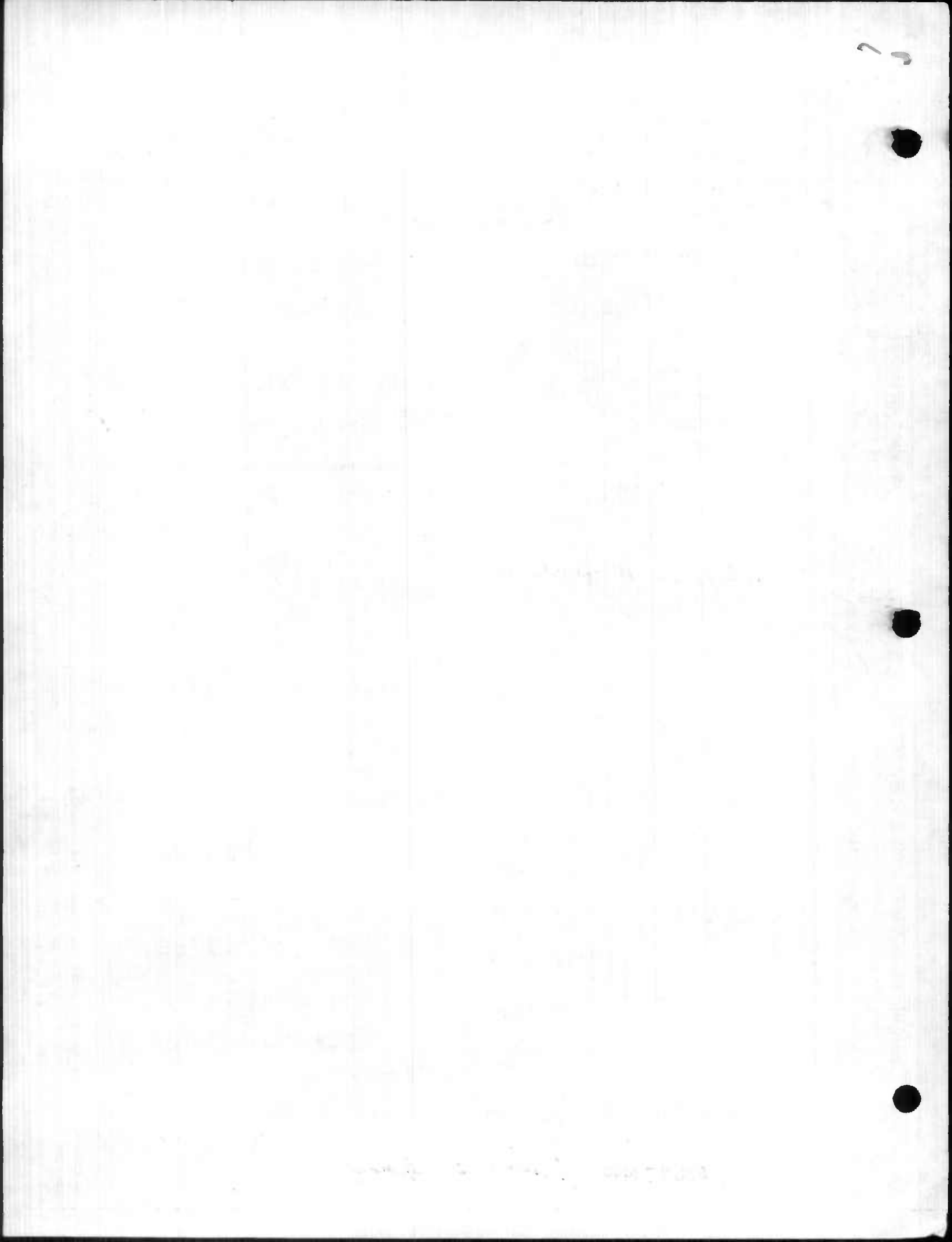
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | |
|--|--|---|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Alexis Lewis Smith | | | | 2. Date of Death Month Day Year AUGUST 22, 1999 | | 3. Time of Death 11:41A.M. | |
| | 4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death RANDALLSTOWN | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 191-78-0626 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) Yrs. 2 | If Under 1 Year Months 2 | If Under 24 Hrs. Hours 2 Min. | 8. Date of Birth (Month, Day, Year) June 25, 1999 | | 9. Birthplace (State or Foreign Country) Pennsylvania |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Randallstown | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 9912 Cervidae Lane | | | | 10f. Zip Code 21133 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -0- College (1-4 or 5+) -0- | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None | | | 16b. Kind of Business/Industry ----- | |
| 17. Father's Name (First, Middle, Last) Walter Lee Smith | | | | 18. Mother's Name (First, Middle, Maiden Surname) Jeanna Renee Rothhaupt | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mr. and Mrs. Walter Smith | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9912 Cervidae Lane Randallstown, MD 21133 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Mem. Park | | Date Aug 26 | | 20c. Location - City or Town, State Sykesville, Maryland | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HISTIOCYTOID CARDIOMYOPATHY Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 23, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARRY A. D. KOSKOWSKI 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature  | | | | | | |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 26989

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY STANLEY

2. Date of Death

Month Day Year
AUGUST 25 1999

3. Time of Death

1:30 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

202 MIDDLEWAY ROAD # 1D

4b. City, Town, or Location of Death

MIDDLE RIVER

4c. County of Death

BALTIMORE

5. Social Security Number

215 12 7501

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
OCT 21 1923

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

MIDDLE RIVER

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

202 MIDDLEWAY ROAD # 1D

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

NURSES AID

16b. Kind of Business/Industry

HOSPITAL

17. Father's Name (First, Middle, Last)

ALEXANDER STPCZUK

18. Mother's Name (First, Middle, Maiden Summa)

HELEN UNK.

19a. Informant's Name/Relationship (Type, Print)

SHARON RANDOL / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6501 ARBOR LANDING DRIVE CHESTER, VIRGINIA 23831

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

METRO CREMATORY

Date

8/26/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CVACH/ROSEDALE FUNERAL HOME

1211 CHESACO AVE BALTO, MD 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. myocardial infarction
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Pernicious Anemia

Hypothyroidism, Osteoarthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D13401

29d. Date signed (Month, Day, Year)

8/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.H. SHERBOURNE 9101 FRANKLIN S & D. BALTO MD 21237

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26990

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROBERT JOHN SALBERG | | | | 2. Date of Death Month Day Year AUGUST 25, 1999 | | 3. Time of Death 2:07 AM | |
| | 4a. Facility Name (If not institution, give street and number) VAMHCS FORT HOWARD DIVISION | | | | 4b. City, Town, or Location of Death FORT HOWARD | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 331-28-5382 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 | | 8. Date of Birth (Month, Day, Year) Feb. 16, 1934 | |
| | 9. Birthplace (State or Foreign Country) Chicago, IL | | 10a. Usual Residence of Decedent 10e. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore City | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 3018 East Baltimore Street | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1956-58 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesperson | | 16b. Kind of Business/Industry Retail Sales | | | |
| | 17. Father's Name (First, Middle, Last) Joseph Brenald Salberg | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anne C. Hanson | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mrs. Sally Britton/Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Starry Road Sequim, Washington 98382 | | | |
| Physician /Medical Examiner | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. | | 20c. Date 8/26/99 | | 20d. Location - City or Town, State Towson, Maryland | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. PROSTATE CARCINOMA Due to (or as a consequence of): f. BONE METASTASES Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): Approximate Interval Between Onset and Death 1 YEAR 1 YEAR | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Were an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier | | 29c. License number 34359 (OHIO) | | 29d. Date signed (Month, Day, Year) 8-25-99 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. JOHN LAH, MD--9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26991

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert T. Sowinski | | | | 2. Date of Death Month Day Year AUGUST 23, 1999 | | 3. Time of Death 1353 PM | | |
| | 4a. Facility Name (If not institution, give street and number) 8232 OLD HARFORD ROAD | | | | 4b. City, Town, or Location of Death PARKVILLE | | 4c. County of Death BALTIMORE | | |
| Funeral Director | 5. Social Security Number 220-20-8445 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 71 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 7, 1928 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD. | | 10b. County Baltimore | | 10c. City, Town or Location Parkville | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 8232 OLD Harford Rd. | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 yrs | | College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Meat Cutter | | 16b. Kind of Business/Industry Giant Grocery | | | |
| 17. Father's Name (First, Middle, Last) Stanley John Sowinski | | | | 18. Mother's Name (First, Middle, Maiden Surname) Agnes Stemper | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Stanley T. Sowinski / Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4610 Todd Point Lane Edgemere, MD 21219 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Belair Evans Funeral Chapel MD | | 20c. Location - City or Town, State Belair, MD. | | 20d. Date 8/25/99 | | | |
| 21. Signature of Funeral Service Licensee Andre Amato | | | | 22. Name and Address of Facility Evans Chapel of Memories 8800 Harford Rd | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Post ventricular fibrillation Due to (or as a consequence of): b. Myocardial Infarction Due to (or as a consequence of): c. Coronary Artery Disease Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? limited <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. Signature and title of certifier Theodore King M.D. | |
| | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 24, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | |
| 31. Date of registration (Month, Day, Year) AUG 27 1999 | | 32. Registrar's Signature Sparks | | 33. Registrar's Title Registrar | | 34. Registrar's Address 111 Penn Street, Baltimore, Maryland 21201 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text, mostly illegible due to fading. Some words like "The" and "and" are visible.

Handwritten text, possibly a signature or a specific heading, centered on the page.

Handwritten text at the bottom of the page, possibly a date or a reference.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26992

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Donald F. Seling Sr. | | | | 2. Date of Death Month August Day 24 Year 1999 | | 3. Time of Death 9:50 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) 4729 Fawn Grove Road | | | | 4b. City, Town, or Location of Death Pylesville | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 215-34-0336 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) May 5, 1937 | |
| | 9. Birthplace (State or Foreign Country) Balto. Co., MD. | | 10a. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Pylesville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 4729 Fawn Grove Road | | 10f. Zip Code 21132 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 yrs. College (1-4 or 5+) n/a | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Builder | | 16b. Kind of Business/Industry Seling Homes | | 17. Father's Name (First, Middle, Last) Bernard Christopher Seling Sr. | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Genevieve Kahler | | 19a. Informant's Name/Relationship (Type, Print) Mrs. Marie Lisa Seling (Wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4729 Fawn Grove Road Pylesville, MD. 21132 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) BelAir Memorial Gardens | | 20c. Date 8/28/99 | | 20d. Location - City or Town, State BelAir, MD. 21014 | | 21. Signature of Funeral Service Licensee Charles Padgett | |
| | 22. Name and Address of Facility E.F. Lassahn Funeral Home, P.A. 11750 Belair Road Kingsville, Maryland 21087-1351 | | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lung Cancer | | 23b. Approximate Interval Between Onset and Death 10 mon | | 23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 23d. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 23e. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24a. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| | 24c. Describe how injury occurred | | 24d. Location (Street and Number or Rural Route Number, City or Town, State) | | 25. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 26. Date of Injury (Month, Day Year) Aug 27 1999 | |
| To Be Completed by Physician/Medical Examiner | 26. Time of Injury M | | 26. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 26. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 27a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 27b. Signature and title of certifier Charles Padgett MD | | 27c. License number D15546 | | 27d. Date signed (Month, Day, Year) Aug 24, 1999 | |
| State Registrar | 28. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Padgett, MD, 5601 Loch Raven Blvd, Baltimore, MD 21239 | | 28. Date filed (Month, Day, Year) Aug 27 1999 | | 28. Registrar's Signature P. Sparks | | 28. Date of Death Aug 24, 1999 | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26993

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George A. Ulbig Sr.

2. Date of Death

August 24 1999 2:35 AM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-24-2735

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

9-15-28

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1123 Mace Ave.

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

3

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Crane Operator

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Herman Ulbig Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary B. Baker

19a. Informant's Name/Relationship (Type, Print)

Janet L. Ulbig / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1123 Mace Ave. Essex, MD 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

8-27-99

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

Denise S. Kelly

22. Name and Address of Facility

Cvach/Rosedale Funeral Home
1211 Chesaco Ave. Rosedale, MD 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Gastrointestinal Bleed

Approximate Interval Between Onset and Death

7 Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung Cancer with Metastasis to Livers
Cirrhosis

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rina Garuda MD

29c. License number

RD 191734

29d. Date signed (Month, Day, Year)

8/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Rina Garuda 9000 Franklin Square Drive Baltimore, MD 21237

31. Date Filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

A. Sparks

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26994

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Franc S. Valentine

2. Date of Death

Aug 25, 1999

3. Time of Death

8 AM

4a. Facility Name (If not institution, give street and number)

Levindale Hebrew Geriatric Center & Hosp.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

112-18-1221

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

March 3, 1905

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10729 Park Heights Avenue

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerical

16b. Kind of Business/Industry

Federal Reserve Bank

17. Father's Name (First, Middle, Last)

Raymond Edward Schreiner

18. Mother's Name (First, Middle, Maiden Surname)

Emma Unknown

19a. Informant's Name/Relationship (Type, Print)

Bertram Potempkin (Attorney)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

425 St. Paul Street, Baltimore, MD 21202

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

08/26

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Nicholas G. Kratter

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute cardiac arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery disease

Due to (or as a consequence of):

c. ventilator dependent

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

Hypothyroidism decubiti

osteoporosis

atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Consuelo Alvarez

29c. License number

D:44907

29d. Date signed (Month, Day, Year)

August 25th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2434 West Belvedere Ave, Balto, MD 21215

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

Emma B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26995

AMENDED #31 PER DVR G774 8/27/99 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clay Franklin Welch

2. Date of Death

Month

Day

Year

August 23 1999

3. Time of Death

7:47 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

215-14-6681

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

07-01-1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Pikesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

711 Templecliff Road

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

2 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Paper Handler-Press Room

16b. Kind of Business/Industry

Baltimore Sun Newspaper

17. Father's Name (First, Middle, Last)

Harry C. Welch

18. Mother's Name (First, Middle, Maiden Surname)

M. Lillian Forney

19a. Informant's Name/Relationship (Type, Print)

Betty V. Welch (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

711 Templecliff Road Pikesville, Maryland 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Memorial Park

Date

8-26-99

20c. Location - City or Town, State

Sylesville, Maryland

21. Signature of Funeral Service Licensee

J. Wayne Osterling

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Road Randallstown, Maryland 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

b. Redo Coronary Artery Bypass Graft Surgery

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Karen Weber D.O.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

August 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karen Weber Sinai Hospital 2401 W. Belvidere Ave Baltimore M.D. 21215

31. Date filed (Month, Day, Year)

8/23/99 AUG 27 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

100-442-100-2

100-442-100-2

100-442-100-2

100-442-100-2

100-442-100-2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 26996

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Herman Westkamp

2. Date of Death

Aug 24 1999

3. Time of Death

2:14A

4a. Facility Name (If not institution, give street and number)

Long Green 115 E. Melrose Ave.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-09-1135

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JULY 3, 1919

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

607 S. BELNORD AVE.

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10TH

College (1-4 or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

WAREHOUSE WORKER

16b. Kind of Business/Industry

WESTINGHOUSE

17. Father's Name (First, Middle, Last)

JAMES WESTKAMP

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET DUVAL

19a. Informant's Name/Relationship (Type, Print)

GORDAN WESTKAMP/BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1100 DULANEY GATE CIRCLE, COCKEYSVILLE, MD. 21030

20e. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GARRISON FOREST VA

Date

8/26/99

20c. Location - City or Town, State

OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

Elizabeth Selinski

22. Name and Address of Facility

CHARLES S. ZEILER & SON, INC.
6224 EASTERN AVE. BALTIMORE, MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Failure to Thrive

Approximate Interval Between Onset and Death

1-2 wks

Due to (or as a consequence of):

Pneumonia

2 wks

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Rapidly progressive Dementia unspecified type

1 month

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24e. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending investigation☐ Accident☐ Suicide☐ Homicide☐ Could not be determined

28e. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Paul Schwartz M.D.

29c. License number

D17118

29d. Date signed (Month, Day, Year)

8/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Schwartz M.D. 115 E. Melrose Ave 21212

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

Benjamin A. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

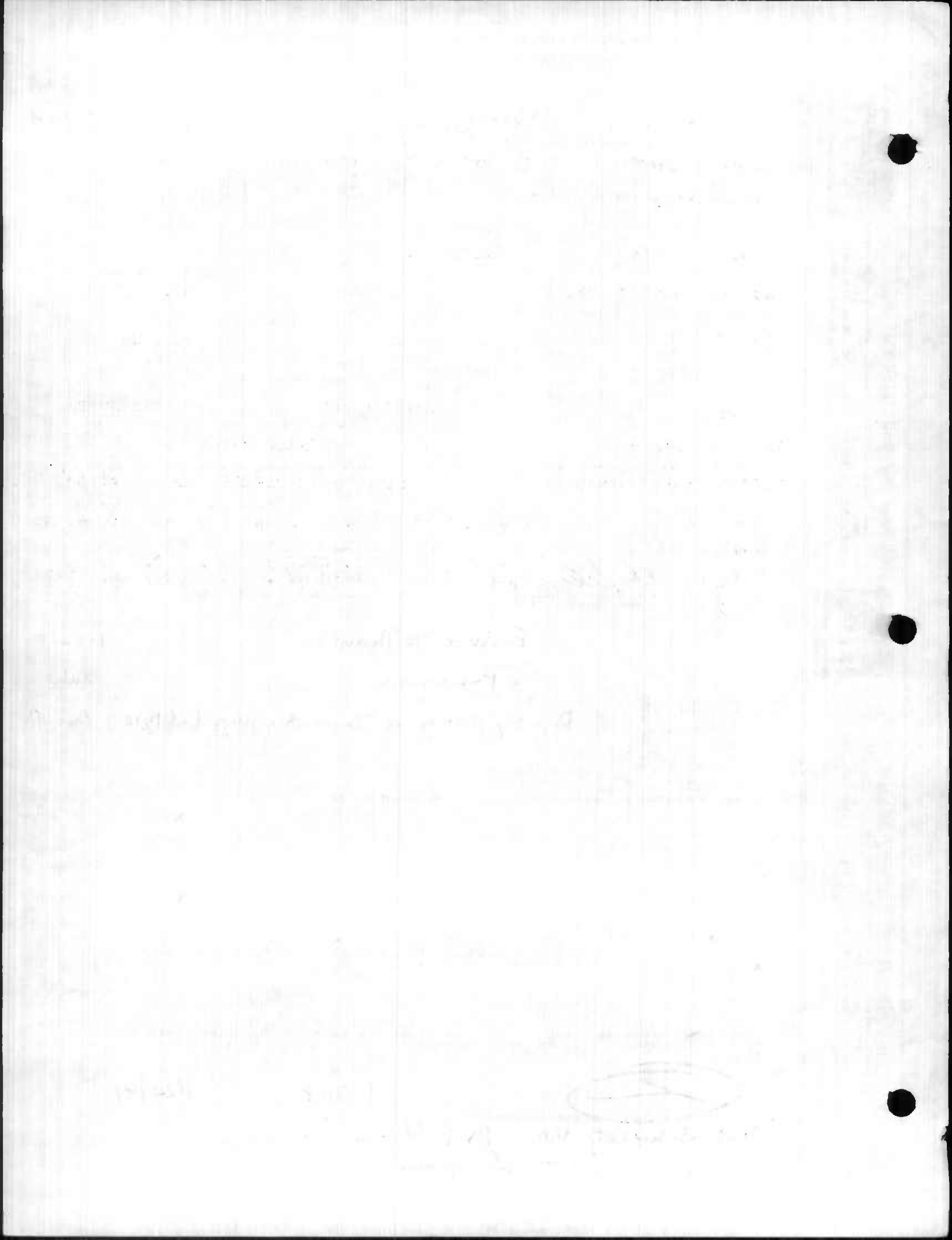
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26997

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Sadie Williams

2. Date of Death

Month Day Year 8 25 99

3. Time of Death

3:45 PM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

217-32-8264

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 4 27 10

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2110 Park Avenue

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 6 College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Building Maintenance

16b. Kind of Business/Industry #130

Balto. City School

17. Father's Name (First, Middle, Last)

Phillip Minor

18. Mother's Name (First, Middle, Maiden Surname)

Emma Clayborne

19a. Informant's Name/Relationship (Type, Print)

Phillip Russell Williams

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

301 ILchester St. Balto, Md. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial L.P.C.

Date

8/31

20c. Location - City or Town, State

Arbutus, Md.

21. Signature of Funeral Service Licensee

Shirley Williams

22. Name and Address of Facility

MARSHALL W. JONES JR. F.H.P.A.

4101 Edmondson Ave. Balto, Md. 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Atherosclerotic Cardiovascular

Approximate Interval Between Onset and Death

yrs

Due to (or as a consequence of):

Diabetes

yrs

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Amatun H. Maem

29c. License number

D15503

29d. Date signed (Month, Day, Year)

8, 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMATUN H. MAEEM, 501 Dolphin St, Balto MD 21217

31. Date filed (Month, Day, Year)

AUG 27 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

MEMORANDUM

TO : Mr. [illegible]
FROM : Mr. [illegible]
SUBJECT : [illegible]

1. [illegible]
2. [illegible]
3. [illegible]

4. [illegible]
5. [illegible]
6. [illegible]
7. [illegible]
8. [illegible]

9. [illegible]
10. [illegible]
11. [illegible]
12. [illegible]
13. [illegible]

14. [illegible]
15. [illegible]
16. [illegible]
17. [illegible]
18. [illegible]

19. [illegible]
20. [illegible]
21. [illegible]
22. [illegible]
23. [illegible]
24. [illegible]
25. [illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 26998

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Darric Anders

2. Date of Death

Month Day Year
AUG. 7 1999

3. Time of Death

6:06 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

FORT WASHINGTON HOSPITAL

4b. City, Town, or Location of Death

FORT WASHINGTON

4c. County of Death

PRINCE GEORGES

5. Social Security Number

242-30-6512

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 16, 1911

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

WASHINGTON DC

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1708 FORT DAVIS ST S.E.

10f. Zip Code

20020

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

AIRLINE ATTENDANT

16b. Kind of Business/Industry

AIR TRAVEL

17. Father's Name (First, Middle, Last)

ALBERT ANDERS

18. Mother's Name (First, Middle, Maiden Surname)

VICTORIA TOON

19a. Informant's Name/Relationship (Type, Print)

BEVERLY POWELL / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

803 NEWMONT ST. FORT WASHINGTON, MD 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. OLIVET CEMETERY

Date

8-12-99

20c. Location - City or Town, State

WASHINGTON DC

21. Signature of Funeral Service Licensee

Alex S. Pope Jr.

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOME

2617 PENN. AVE S.E. WASHINGTON DC 20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

ASCVD

Due to (or as a consequence of):

Atherosclerotic Cardiovascular

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Disease

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alex S. Pope Jr. MD

29c. License number

002259

29d. Date signed (Month, Day, Year)

Aug 7, 1999

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

René Grace MD 9131 Piscataway Rd, Clinton MD 20735

31. Date filed (Month, Day, Year)

AUG 12 1999

32. Registrar's Signature

James B. Spence

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1000 1000 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 27000

| | | | | | | | | |
|--|---|---|--|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Carl Jshonte Black, Jr. | | | | 2. Date of Death Month Day Year August 07, 1999 | | 3. Time of Death 10:37 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center | | | | 4b. City, Town, or Location of Death Cheverly | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 579-02-2459 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 19 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 16 1980 | |
| | 9. Birthplace (State or Foreign Country) Wash., D.C. | | 10a. State Virginia | | 10b. County Richmond | | 10c. City, Town or Location Richmond | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 306 W. Charity St. | | 10f. Zip Code 23220 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (14 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook | | 16b. Kind of Business/Industry Private | | | | |
| 17. Father's Name (First, Middle, Last) Carl Randolph Black | | | | 18. Mother's Name (First, Middle, Maiden Surname) Tanya Patricia Boone | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Carl R. Black - Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3400 Lumar Dr., Ft. Washington, MD 20744 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lee's Crematory | | 20c. Date 8/14/99 | | 20d. Location - City or Town, State Clinton, MD | | |
| 21. Signature of Funeral Service Licensee John T. Stewart III | | | | 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. GUNSHOT WOUND TO TORSO AND GUNSHOT WOUND TO LEG Due to (or as a consequence of): b. Ltg Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 8-7-99 | | 28b. Time of Injury 1:04 A M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred SUBJECT WAS SHOT. | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) POUNCE LOT | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3411 DAWSONE PRINCEGEORGES MD | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Katherine McKelvey M | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) August 09, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARSHALL A. KORN 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1999 | | | | 32. Registrar's Signature B. Smith | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

